

**Trauma Counselling: Perceptions of clients at The Trauma
Centre for the Survivors of Violence and Torture**

By

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of the
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**Dedicated to my parents who taught me that the
pursuit of knowledge is not only necessary but it is also noble.**

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Abstract

A trauma can be defined as an event which attacks the defences and psychological well-being of the person (Mitchell & Everly 1997). Trauma has the capacity to significantly disrupt a trauma victim's life and many authors describe the impact that a traumatic event can have on an individual. Trauma counselling is often required to assist the victim to return to their premorbid levels of functioning. This study provides the reader with relevant literature into the subjects of trauma and trauma counselling.

There were two research questions which formed the basis of the study and these research questions focussed on how the respondents experienced the trauma counselling they had received and how they felt that the counselling assisted them with achieving post-traumatic growth. In order to investigate these research questions a combination of qualitative and quantitative methods were used. Respondents were asked to participate in an unstructured interview and to complete two Revised Impact of Event Scales. The researcher had also constructed an interview schedule which was used to guide her in terms of data that needed to be obtained.

Systematic sampling was employed in this study. A pilot study was conducted with three respondents and thereafter the study was conducted with twenty respondents. All of the respondents had been involved in a traumatic event and all of them had completed trauma counselling at The Trauma Centre for Survivors of Violence and Torture in Cape Town in the previous six months.

From the results of the study it can be concluded that all of the respondents had a positive counselling experience. This can be attributed to a number of factors which are discussed in the final chapter of this document. Another important finding was that ninety percent of the respondents had discussed other issues, besides the trauma, in their counselling and they felt that trauma counselling had assisted them with achieving growth in self-awareness.

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Chapter One

Problem statement

In this chapter I introduce the reader to the rationale behind this study which is based on the literature that confirms that any traumatic event can overwhelm an individual. A brief overview of the literature pertaining to this study is also provided. This chapter also contains a detailed discussion of the research design and methodology utilised in this study. The ethical considerations and limitations of this research are also clarified and the researcher also declares her personal issues which are relevant to the research.

1.1 Problem formulation

The issue of service quality has become an international issue. Van Niekerk (1998) states that if the service of an organization is of high quality, clients will continue to make use of the service. In the case of non-governmental organizations (NGO's) this is even more important because "the capacity of non-governmental organizations to deliver goods and services in an efficient and effective way has become the key criterion for continued donor support" (Patel, 1998:115).

In the current global economic climate "evaluation of practice is a requisite" (Baer, 2001:127). This research is significant because it will provide the organization with feedback from clients. The centre adopted a new model of working last year where an appointment system was introduced and it was expected that this study could also evaluate whether this has been effective or not.

The Trauma Centre is an NGO (this will be discussed in greater detail under concept clarification), which has recently faced a funding crisis and it is in the process of examining how it can ensure its sustainability. In order to survive, NGO's have to provide a high-quality, effective and efficient service so as to ensure continued donor support.

Trauma counselling at The Trauma Centre can be seen as falling into two categories: 1) there are clients who do not return after a debriefing session (debriefing will be discussed in greater detail in chapter two). It is assumed that these clients once they understand their symptoms do not feel the need to continue with counselling.

2) Clients who engage in ongoing counselling.

The clients who continue with counselling usually use the process to deal with underlying issues as well because the trauma seems to provoke these issues. Once the clients are assisted to deal with these issues they experience some form of growth in self-awareness. This growth in self-awareness has not been systematically evaluated.

The Centre introduced an appointment system in 2002 whereby clients now make an appointment for their first session and all follow-up sessions are by appointment only. The Centre still caters for clients who walk in to the Centre without an appointment but people are encouraged to make appointments beforehand. In the past all clients were seen on a first come first served basis which meant that clients often waited for up to three hours to be seen. The appointment system was introduced to prevent clients from having to wait indefinitely to be seen. Clients usually have one hour sessions once a week. The new appointment system has not been evaluated.

1.1.1 Research questions

The two main research questions are:

- a) How have clients experienced the counselling they received?**
- b) How do clients feel counselling helped them to achieve growth in self-awareness?**

These questions encompass sub questions of how clients experience the new appointment system, the past and present symptoms of clients, whether there has been a subjective improvement in their condition, their sense of growth in self-awareness and their opinions of the general services at the Centre in the management of trauma.

1.1.2. Research aims

The aims are:

- a) To describe clients' subjective experience of the counselling process in the management of trauma.**
- b) To determine clients' opinions on how counselling assisted them to achieve post-traumatic growth in the form of greater self-awareness.**

The objectives are to determine:

- a. To determine what symptoms clients had on presentation to the service.
- b. To determine their current symptoms.
- c. To determine what recommendations clients have for the Centre regarding the counselling.
- d. To determine whether the new appointment system is useful or not in helping to decrease clients' anxiety about coming for counselling.
- e. To determine whether clients would recommend the Centre to others.
- f. To determine what the reasons for the termination of treatment were.
- g. To determine whether clients dealt with other issues besides the traumatic event in counselling.
- h. To examine the relationship between the client and the counsellor.
- i. To determine whether clients had other support besides the counselling.

1.2 Concept clarification

The Trauma Centre - is based in Woodstock, Cape Town and it is celebrating its tenth anniversary in 2003. It is a Non-governmental Organization (NGO), its main funder being the European Union. The Trauma Centre treats any person who has been involved in a violent traumatic incident (with the exception of domestic violence, rape or child abuse because there are other organizations that specialise in these areas) and also deals with refugees. The Centre is a free counselling service and does not provide material assistance. Social workers, psychologists, a psychiatric registrar and two aroma therapists make up the staff complement of thirty-nine.

The aroma therapists service the clients and staff, who are entitled to four massages per annum.

Trauma – The word trauma has a dual definition, which encompasses “a wound especially one caused by sudden physical injury and an emotional shock that creates substantial and lasting damage to the psychological development of the individual” (Webster’s II Dictionary in Scignar, 1996: 27).

In this study the definition which states that “a trauma is an event which attacks the psyche and breaks through the defence system with the potential to significantly disrupt one’s life” (Mitchell & Everly 1997: 7) will be used.

Debriefing – This is an opportunity for the client to ventilate about the incident in a structured way. Traditionally the debriefing model is used with groups but it can also be used with individuals (Mitchell & Everly, 1997).

Primary victims - Mitchell and Everly (1997) define ‘primary victims’ as those people who are directly affected by a trauma.

Counselling – “is the skilled and principled use of relationships which develop self-knowledge, emotional acceptance and growth, and personal resources. Counselling may be concerned with addressing and resolving specific problems, coping with crises, working through inner feelings and inner conflict, or improving relationships with others” (Rowland et al, 2000: 223).

Perceptions – The Oxford Dictionary (1992:507) defines this as the ability to perceive which it clarifies as “having or showing insight and sensitive understanding”.

Crisis – The word crisis refers to “an acute emotional upset arising from situational, developmental, or sociocultural sources and resulting in a temporary inability to cope by means of one’s usual problem-solving devices” (Hoff, 1995:4).

1.3 Theoretical foundations for trauma management

Many authors describe the impact that a traumatic event can have on an individual (Burgess & Lazarre 1976, Herman 1992, Davis et al 1996, Scrignar 1996, Williams et al 1999).

Traumatic events are overwhelming not because they occur rarely but because they overwhelm the individual’s ability to cope (Herman 1992).

The first step in professional intervention with trauma usually involves debriefing the individual. It is recommended that debriefing occur within 24-72 hours after the event (Mitchell & Everly, 1997). There is an ongoing debate whether debriefing is beneficial or not but various studies support debriefing (Petevi et al 1993, Bass and Davis 1994, Hajjiannis & Roberts 1999, Stacey 1999, Crossley 2000, Rynearson 2001). Many studies oppose its use (Raphael & Lenore 1995, Appelt 2003 cites eleven studies that oppose debriefing).

If a traumatic event is not dealt with it can lead to Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD) (Scrignar, 1996). These disorders are similar; however, the major distinction between the two is related to the duration of the symptoms. With ASD the symptoms last for no less than two days and not more than one month. Unlike PTSD, which can arise up to six months after the trauma, the symptoms have to arise within four weeks of the trauma (Scignar, 1996).

In order for PTSD/ASD to be treated successfully it has to be diagnosed correctly and an analysis of how the trauma has impacted on the client has to be made (Scrignar, 1996). Treatment can be effected through various models which are used to treat PTSD/ASD and there are international models (Herman 1992, Scrignar 1996, Harvey, 1998) and South African treatment models. The similarities between these treatment models will be discussed in chapter two. The literature confirms that the counselling relationship is an integral part of treatment and largely determines whether treatment will be successful (Howe 1993, Mitchell 1993, Saunders 1999, Keijsers 2000, Torgalsboen 2001, Williams 2002)

It also evident from the literature that ethics and supervision play an important role in the counselling relationship (Banks1995, Corey 1996, Coady & Bloch 2002, Freitas 2002, Henry Hensley 2002). Furthermore a number of authors discuss the various ways in which individuals can grow from a traumatic event (Wright1991, Hybels-Steer 1995, Matsakis 1998, Lifton and Olson in Horowitz 1999).

The theoretical framework that underpins the counselling at the Trauma Centre can be described as an integrated approach which is based on a number of different approaches.

A number of theorists argue the importance of using an integrated approach (Dryden 1992, Comas-Diaz 1994, Corey 1996).

The approach used by the Centre has been adapted from the following approaches: 1) Crisis Intervention, 2) Narrative Therapy, 3) Brief Psychodynamic Psychotherapy, 4) Systemic Integrated Psychotherapy and Cognitive Therapy. These approaches will be discussed in more detail in the chapter two. It is, however, important to note that all the approaches emphasise the significance of the counselling relationship. In fact they all contain guidelines for how the counsellor has to engage with their clients and what the nature of the relationship should be in order for the treatment of trauma to be successful.

1.4 The Trauma Centre's training programme

All the new counsellors at the Centre are required to attend an orientation programme which aims to familiarise them with how the organization functions. They are also trained in trauma management because it is the opinion of the management and staff at the Centre that trauma counselling is a specialised form of counselling. Other staff members attend when they feel in need of reacquainting themselves with some of the theoretical aspects of trauma counselling. Staff of the Centre conduct this training.

The training programme consists of the following subjects:

- 1) Definitions of trauma and crises.
- 2) Crisis intervention theory.
- 3) Theory and debates around debriefing.
- 4) Models of crisis intervention and debriefing.
- 5) Crisis counselling.
- 6) Skills in trauma counselling.
- 7) Ethical issues in the treatment of traumatised individuals.
- 8) Grief, loss and trauma.

The Centre also has ongoing training in the form of workshops, inviting guest speakers to present papers on trauma management and staff are encouraged to attend conferences and courses which are relevant to the work of the Centre. An important aspect of the performance reviews of counsellors is identifying their training needs and once these training needs are identified a plan outlining how these needs will be met is devised.

1.5 Research design and methodology

This research can be seen as falling under the ambit of applied research, which means that the aim of this study is to “develop solutions for problems and applications in practice” (De Vos et al, 1998:8). Both qualitative and quantitative designs are employed in this study. The primary design in this study was, however, a qualitative one because in trauma the individual responds in a very complex manner and the response consists of emotional and physical components.

I decided to use both approaches based on the fact that De Vos et al (1998) argues that it is useful to use both qualitative and quantitative approaches because the combination of these approaches allows for complex phenomena to be examined in their entirety.

This research can also be seen as evaluative research and “evaluation must be an integral dimension of social work and social care practice” (Shaw & Lishman, 1999:1). A number of methods can be used to measure effectiveness of services and one way of doing this is to look at how clients see the service (Cheetham, 1994) which is addressed in this research in both quantitative and qualitative ways.

I will first discuss the motivation for using a qualitative approach.

1.5.1. Motivation for the qualitative approach

De Vos et al (1998:243) states in qualitative research “the unit of analysis is holistic, concentrating on the relationships between elements”.

One of the primary aims of this research is to investigate the relationship between the client and the counsellor and how this can be improved because it is believed that this relationship is an integral determinant of the success of counselling. Qualitative research is valuable because it “yields results that develop practice wisdom necessary for intervention and problem solving” (Babbi & Mouton, 2001:248).

Babbi and Mouton (2001) add that with qualitative research, the researcher is non-intrusive unlike in the quantitative approach, which emphasises control on the part of the researcher. In this study this was important because all trauma survivors have experienced a loss of control and their personal space being intruded upon. It was therefore important for the research to be conducted in a non-intrusive manner.

1.5.2 Motivation for quantitative approach

The quantitative approach can be used when the researcher has specific questions, which will remain constant throughout the study, and measurement is focused on specific variables. Data collection methods are designed in advance and applied in a standardised manner (De Vos et al, 1998). In this study there are specific and constant symptoms related to trauma, which are measured. Thus a quantitative design is used to elicit this information.

1.6 Data collection

1.6.2 Unstructured interview with a schedule

This method of qualitative data collection is employed in this research. “Unstructured interviews are conducted with the use of a research schedule. The schedule is a guideline for the interviewer and contains questions and themes that are important to the research” (De Vos et al, 1998:299).

These questions do not have to be asked in a particular sequence but rather act as a guide. The advantage of this method of data collection is that it ensures that data is gathered in a systematic manner and that important information is not omitted while allowing the respondents to give an account of their experience and meaning of the event (De Vos et al, 1998).

I decided to use interviews because reliving of a trauma and counselling can be very intense experiences and subjects required privacy in order to relive their counselling experiences. To approach the personal experience, the privacy of the individual interview was considered more suitable.

A copy of the interview schedule is attached as Appendix II.

1.6.1 Questionnaires (Quantitative Data Collection)

Questionnaires may be used “for descriptive, explanatory and exploratory purposes. They are chiefly used in studies that have individual people as the unit of analysis” (Babbi & Mouton, 2001:232). The purpose of a questionnaire is to gather facts and opinions from the participants about a topic with which they know about (De Vos et al, 1998:153).

An established scale is used to assess which symptoms of PTSD/ASD clients had when they commenced counselling and which symptoms they currently have (see appendix I).

This scale is known as the Revised Impact of Event Scale (IES-R). Appelt (2003) also includes this scale in the research which she conducted at The Trauma Centre. Appelt (2003) found this scale to be suitable for research of this nature.

The Impact of Event Scale (IES) was devised by Horowitz in America in 1979 and this scale was a self-report questionnaire, which could be applied to any specific life event. It elicited the two most often reported categories of symptoms as a result of trauma. These categories related to avoidance of stimuli associated with the trauma and intrusive symptoms.

The significance of this scale is that the data collected on it were used as support for the recognition of Post-Traumatic Stress Disorder (PTSD) as being a psychiatric diagnosis (Weiss and Marmar in Wilson and Keane, 1997). PTSD will be discussed in more detail in chapter two.

The IES-R came about because it was found by Weiss and Marmar in Wilson and Keane (1997) that a thorough assessment of PTSD required an assessment of symptoms of hyper arousal as well. They then included additional items but also maintained some elements so as to not alter the IES too drastically e.g. they maintained the frequency response directions (Weiss and Marmar in Wilson and Keane 1997). I decided to use this scale after consultation with colleagues at the Centre where it was agreed that the scale does have face and content validity despite being standardised in the United States.

A copy of the questionnaire is attached as Appendix I

1.7 Sample design

The first step was to obtain permission to conduct the study from the director of the facility. I then informed the staff of the study. The names of clients who attended the Centre in the past six months were obtained from the statistics records that all counsellors have to submit. Clients who met the criteria of this study were then systematically selected. As mentioned earlier, I work at the Centre but I did not include any of my clients because I thought that this would introduce bias to the study in the form of respondents feeling uncomfortable about giving negative feedback about their counselling.

To be more specific systematic sampling was employed. The total number of clients who terminated counselling was sixty. I required a sample of twenty clients which was suited to the scope of academic requirements and a list of all clients seen at the Centre in the past six months was obtained. The third name on the list was the first subject. Thereafter every third person was chosen.

In this case, Babbi and Mouton (2001) highlight the importance of doing a pilot study because they say that no matter how carefully one designs a questionnaire the researcher will always make a mistake; for example by asking a confusing question.

Moreover, they add that piloting is essential where subjects come from different language and cultural groups as in this case.

1.8 Pilot study

I conducted a pilot study with three clients to ensure that my data collections tools were obtaining the information that I required and subsequently added four questions to my interview schedule. After I had made the necessary corrections, I contacted the sampled clients telephonically in order to explain the purpose of the study and to reassure them that their participation was voluntary.

I clarified that the purpose of the study was twofold in that I was conducting an evaluation of the work of the Centre and that the study was also part of my academic requirements for my Masters degree. Issues such as confidentiality, the aims of the study and feedback to subjects were also discussed. I also reassured them that their response would remain anonymous.

Once a client agreed to participate, arrangements were then made to meet for an interview at a venue of their choice. Interviews were conducted at different locations including clients' homes, their work places and at the Trauma Centre.

A number of people were excluded from the research for various reasons:

- 1) One client refused to participate in the study. I accepted his refusal and did not probe what the reasons were.
- 2) Three clients did not respond to messages from me and I did not pursue this because I did not want the clients to feel harassed.
- 3) Two clients said that they would contact me to let me know their decision and did not.
- 4) One client moved to Durban.
- 5) Two clients' contact details could not be found.

- 6) Ten clients were not appropriate for the study because of various reasons.

When clients were excluded I selected the next name on the list, which contained the names of all the clients.

1.9 Data analysis

I used both qualitative and quantitative data analysis methods consistent with the methods of data collection.

1.9.1 Qualitative data analysis

Qualitative data analysis was used which according to Babbi and Mouton (2001) refers to the analysis of data which was collected using qualitative means. In terms of this study the data were recorded and transcribed. A third party did the transcriptions but I informed the clients of this. Once this was completed I used Tesch's eight steps as discussed in De Vos et al (1998).

Tesch in De Vos et al (1998:344) suggests that the researcher must read through all the transcripts to get a sense of the data. One transcript is selected and the researcher makes notes about the meanings of the data. Once this has been done with several transcripts a list of all the topics is compiled and similar topics are clustered together and codes are then developed by the researcher. Categories are formed and each category is abbreviated. The data belonging to each category is compiled and the researcher does a preliminary analysis. Existing data is recoded if necessary.

1.9.2 Quantitative data analysis

De Vos et al (1998) states that quantitative data analysis can also be done manually by a computer. However, they add that irrespective of whether data is processed by a computer or manually, quantitative data is always processed so that it can be quantified. I have chosen to represent the quantitative data in this study in the form of pie charts because the focus of my results is on the frequency with which certain symptoms occurred.

1.10 Limitations of the study

The limitations of this study will be highlighted using the following headings:

1.10.1 Research design

The primary design used in this study was that of a qualitative design and qualitative studies can also not be exactly replicated unlike quantitative studies (Babbi and Mouton, 2001).

1.10.2 Researcher bias

The issue of the researcher being employed at the Centre could have influenced the study because subjects may have felt pressure to give positive feedback. I attempted to minimise this possibility by excluding my own clients from the research.

1.10.3 Data collection and analysis

The scale used in this study was standardised in America in the 1970s, which means that it is an old scale and one could question its relevance to the South African context. However, the counselling team reviewed it and agreed that it does have face and content validity. The use of a tape recorder might have inhibited subjects in giving information because they may have had issues around confidentiality.

Therefore data was collected some time after counselling had ended so the respondents had to recall their symptoms and counselling experience and they may have forgotten some of the information. I also think that the Centre must be mindful that contacting clients after they have completed counselling because this could be an issue for the clients and this is was another limitation of the study.

I also interviewed a number of the subjects at work during their lunch times and I was aware that they therefore had limited time available. It is possible that this awareness refuted the information obtained.

1.10.4 The context of the interview

Most of the participants were interviewed two months after their counselling had terminated. They could therefore still have been in the recovery period of the trauma and they may not have had enough time to integrate the trauma into their lives which would have led to them not being completely aware of whether their self-awareness had changed or not.

1.11 Ethical considerations

The ethical considerations were particularly important because all the subjects had a history of being violated and of being vulnerable and distressed. The first consideration was therefore to avoid causing any further harm to them. De Vos et al (1998) states that subjects should be alerted to the possible impact of the study on them and I informed the respondents of the possible effects of the study on them.

I did not want to retraumatise the clients, so I reassured them that their participation was voluntary and I gave anybody who appeared hesitant the option of calling me later to schedule an interview. I therefore did not pressure anybody to participate.

According to De Vos et al (1998) informed consent is also very important and I therefore contacted clients telephonically first so that I could explain the purpose and aims of the research and I again clarified this at the beginning of the interview with the option of non-participation.

In considering the issue of psychological competence and I included only people who had completed treatment because I assumed that they would be psychologically contained. At the end of the interviews in counselling modality, I ensured that all the respondents were contained. I was aware that the interview could evoke feelings in the respondents and I therefore arranged with the counsellors that they would be available to see their clients if necessary.

I informed all the respondents at the end of the interviews that if they felt unsettled as a result of the session that they could contact their counsellor for support be it telephonically or by making an appointment to see them.

With confidentiality as an ethical consideration I explained to the respondents how their names were selected and I reassured them that their identities would be protected by anonymity on the recordings and in the final dissertation. Respondents were introduced using their initials so that third party who was utilised to transcribe the interviews could not identify them.

One of the clients whom I contacted felt strongly that her counsellor should have contacted her before I did, to get permission for me to call her. I allowed her to express her anger and I reassured her that her confidentiality was protected in that I had no knowledge of her sessions and that she was not obliged to participate.

I discussed the client's objections with the staff and we agreed that in future clients would be asked to sign a consent form which requested their permission to be contacted for research when they commence counselling.

1.12 Reflexivity

The discussion of Plummer (2001) of the three sources of bias has guided me with my discussion of reflexivity. I have had my own history of trauma which has been resolved but I was aware that I had to be careful of not allowing that to impact on my research. This has, however not been a problem in my counselling with clients which I have been doing for twelve years. I have been in therapy, which has been very helpful to me and assisted in monitoring my counselling in terms of personal trauma. My research supervisor also assisted in monitoring reflexivity in data collection and analysis. I have been concerned about whether the work done at the Trauma Centre does help clients.

I was aware that I could project my own feelings around the success of therapy and that I had to ensure that this did not affect how I conducted this study. I therefore had to guard against eliciting only favourable responses and making clients feel that they cannot criticise the service.

Most of the respondents were interviewed in their homes after the counselling had ended and they could have felt that the interview indicated concern/interest from the Centre. This would undoubtedly have made them feel valued and they may therefore have felt pressurised to give positive feedback about the counselling. They may also have felt unable to give negative feedback about the Centre's services. At the time of the interview their feedback seemed genuine but this is a factor which needs to be considered when recipients of a service are evaluated in a follow-up context.

I also think that the fact that I am employed at the Centre was both an advantage and a disadvantage. The fact that the staff know me means that they were co-operative and receptive to the study. Nevertheless I was concerned that if the findings were not complimentary that it might lead to tensions in the organization and tension towards me. Consequently my data analysis might have been biased towards positive evaluation of the Centre and of the counselling experience.

I think that my experience in this field was an asset because I was very aware of the issues that subjects may present. I also felt confident that I would be able to hold and contain the information given to me. My relationship skills were another definite strength in that I knew that I would be able to be honest, empathic and act with integrity. I also received supervision as researcher from my supervisor while conducting this research and this has assisted me in remaining focused.

1.13 Chapter outline

This document consists of four chapters:

Chapter one- the first chapter includes the motivation for this study and an overview of the literature which supported the motivation for the research. The research questions, research objectives and key concepts were clarified. The first chapter includes an extensive discussion of the research design and methodology used in this research, limitations of the study, ethical issues around the research and a discussion of the researcher's reflexivity. The chapter concludes with an outline of the remaining chapters.

Chapter two- consists of a review of the literature, which underpinned this study. It will highlight issues around trauma, the diagnosis and treatment of Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) as well as the treatment of these conditions. The literature review will also examine counselling outcomes as well as the characteristics, which counsellors require to ensure the efficacy of counselling.

Chapter three- the penultimate chapter will present the results of the study.

Chapter four- the final chapter will focus on discussion of the key findings of the study and conclusions and recommendations with regard to the findings.

Conclusion

In this chapter I introduced the reader to the rationale behind this study, which is based on the literature, which confirms that any traumatic event can overwhelm an individual. The literature also emphasises the importance of the counselling relationship in determining the outcome of trauma counselling. This chapter also contained a detailed discussion of the research design and methodology utilised in this study. The ethical considerations and limitations of this research were also clarified. The researcher also declared her personal position as client and researcher-practitioner in this chapter.

Chapter Two

Literature review

The literature review will focus on aspects of trauma including: 1) examining what trauma is, 2) the diagnosis and treatment of Post Traumatic Stress Disorder and Acute Stress Disorder, 3) counselling outcomes and characteristics of counsellors which impact on the outcome of treatment, and 4) some of the factors in Post-traumatic growth. A discussion of an integrated approach of counselling which consists of different theoretical frameworks will also be included. Some concluding remarks which will highlight the most important points will complete this chapter.

2.1 What is trauma?

The experiencing of a traumatic event is overwhelming for most individuals and Burgess and Lazarre (1976:192) confirm this with their statement that “few categories of human behaviour provoke more gut level of responses than that of trauma”. Williams et al (1999) add that trauma affects the psyche in a manner which few other experiences do. Traumatic events are extraordinary not because of the frequency with which they occur but because they are so overwhelming to the person experiencing the event (Herman, 1992). There are a limitless number of environmental situations which can traumatise people (Scrignar, 1996). This study will focus on criminal assaults because the Trauma Centre only intervenes with this type of trauma.

Trauma affects all areas of the victim’s life and “the emotional corollaries of crime can be more overwhelming and persistent than its medical or economic consequences” (Davis et al, 1996:22). It is important to know how the perpetrator gained access to the victim, because this impacts on the victim’s reaction and recovery (Burgess & Lazare, 1976). These authors state that there are two ways of access:

- a) *The Blitz attack* – which occurs suddenly and without any warning and in the absence of a relationship between victim and perpetrator. This leads to a sudden disruption in the client’s life.

- b) The *Confidence attack* – whereby the perpetrator often gains access to the victim, in the presence of a relationship, through devious means. The perpetrator then violates the victim's trust and this can occur over a short or long period of time.

Any event which is seen as life-threatening or physically harmful, could lead to Post Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD) (which are defined on page five). Victims of crime will in most cases respond with intense fear and many develop PTSD. A criminal insult can also include physical injury and there is often a disruption in close relationships and functioning at work (Scrignar, 1996). The first stage of treatment in trauma is usually a debriefing of the event.

2.2 Critical Incident Debriefing (CSID)

Debriefing has its origins in the military where it was used to assist soldiers who had undergone traumatic experiences (Mitchell & Everly, 1997). It is based on the assumption that early treatment prevents the development of a psychiatric disorder and that the best time to do a debriefing is within 24-72 hours after the traumatic event (Scrignar, 1996). The most commonly used model of CISD is the Mitchell model (Mitchell & Everly, 1997). This process consists of seven phases and the counsellor follows the phases in a set order.

The phases are 1) the *introductory phase* where the counsellor explains to the client what will happen during the session. After this 2) the *fact phase* focuses on the history of the event and includes recollection of the sensory perceptions. 3) The *cognition phase* deals with the client's thoughts before, during and after the traumatic incident. This is followed by 4) the *reactive phase*, which aims to elicit the feelings around the event. 5) The *symptom phase* identifies the client's symptoms and this is then explained in 6) the *education phase*. The session is concluded with 7) the *wrap up phase* i.e. the session is summarised (Mitchell & Everly, 1997). However, there has been some debate in the literature as to whether debriefing is beneficial or not.

Some of the criticisms of debriefing have been that it does not take into account the clients' past trauma, current and recent life stresses and that because it focuses on the trauma it may lead to secondary traumatisation (Raphael & Lenore, 1995).

Appelt (2003), in an unpublished paper, cites various studies which argue that debriefing is not beneficial. These studies include:

- a) The Cochrane review of 1997 which encompassed eleven studies and which showed that debriefing did not reduce distress of clients nor did it prevent PTSD.
- b) Burns (2002) found little evidence that debriefing was helpful.
- c) A study done by Litz et al (2002) advised that debriefing may not be helpful and that clients should have the option of other methods of treatment.
- d) Ormerod (2002) advised that debriefing could be harmful unless it is part of a treatment programme because it can evoke powerful emotions.

There are, however, also numerous authors who argue that debriefing is beneficial to the client (Petevi et al 1993, Bass and Davis 1994, Hajiannis & Robertson 1999, Stacey 1999, Crossley 2000, Rynearson 2001).

Stacey (Unpublished article, 1999) argues that debriefing is helpful but that the timing of it is important. She argues that The Trauma Centre uses 'crisis counselling' rather than debriefing in its true form. The Trauma Centre approach advocates that the counsellor be flexible and sensitive to the issues raised by the client as well as focusing on the event. The client narrates the story in his or her own words and psychoeducation is an important part of the process.

Bass and Davis (1994:133) capture the essence of the benefits of debriefing in their statement that "telling another human being about what happened to you is a powerful healing force that can dispel the shame of being a victim". Petevi et al (1993:11) add that "debriefing helps people to understand their trauma and the effects it has had on their view of themselves, their families, their communities and their world.

For many this is a soothing revelation". Crossley (2000: 56) in fact states that one of the trauma victims' needs is the 'urge to bear witness' i.e. they need to tell others about the truth of their experience and she says that the process of storytelling is a "personally reconstructive act". This is echoed by Hajiannis and Robertson, (1999) who state that there are many benefits of debriefing, which include the fact that it allows the client to impose a time sequence on the events and it encourages confrontation rather than avoidance of the trauma. Debriefing allows the client to mourn their trauma which is vital because "the descent into mourning is at once the most dreaded and necessary task; however, it is vital for recovery" (Herman, 1992: 188).

Counsellors are in the position where they have to listen to the traumatic material that emerges during the debriefing and this can be emotionally taxing on the counsellor. Rynearson (2001: 36) however states that "the disciplined clinician can tolerate the unspeakable story without being terrorised or losing hope. The clinician's unperturbed presence begins a reassuring alliance so that naming and retelling the unspeakable can begin. There are theories and protocols of treatment that explain symptoms, verifiable diagnoses, but it is the calming alliance and mutual retelling and revising of the dying story (*the violent episode*) that is at the centre of the work."

If the debriefing is unsuccessful it can lead to PTSD/ASD (Mitchell & Everly, 1997).

2.3 POST TRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER

In terms of DSM IV (1994), a diagnosis of PTSD includes new criteria, which represents an improvement in the understanding of a person's reaction to trauma. This understanding focuses on the person's perception of the trauma as well as the reaction to it (Scrignar, 1996). The author further states that there are various criteria, which need to be fulfilled in order to make the diagnosis. This discussion will simultaneously highlight the symptoms of responses to trauma:

Criterion one

The person must have been present at the scene of the trauma and must personally be in danger. The person's response is also important. This recognises an individual's response to trauma and furthermore that a wide range of traumas can lead to PTSD.

Criterion two

Victims of trauma often have experiences where they think that the trauma is recurring. It is important for the counsellor to be aware of this because "the reexperiencing cluster is the *sine qua non* distinguishing PTSD from other anxiety disorders" (Scrignar, 1996: 19). This includes flashbacks of the event, illusions, hallucinations and feeling as if the traumatic event is recurring. The internal or external cues can lead to intense psychological or physiological distress e.g. cramps or headaches.

Criterion three

This includes a persistent avoidance of stimuli associated with the trauma which aims to reduce the anxiety felt by the person. Unfortunately, often as the anxiety decreases the avoidance can increase which often leads to further difficulties e.g. avoidance of work. The traumatised person also presents with symptoms of depression e.g. a lack of interest in life.

Criterion four

The victim often experiences problems with insomnia, difficulties with concentration and hyper vigilance i.e. being overly aware of what is happening around him/her.

Criterion five

In order for PTSD to be diagnosed, symptoms must persist beyond one month of the trauma.

Criterion six

This extends the diagnosis to include observable impairments in functioning. In PTSD, work relations and social activities are often impaired.

Petevi et al (1993) state that the symptoms of trauma can leave people feeling helpless and as if the traumatic event is recurring. Acute Stress Disorder is very similar to PTSD; however, the major distinction between the two is related to the duration of the symptoms. With ASD the symptoms lasts for no less than two days and not more than one month. Unlike PTSD, which can arise up to six months after the trauma, the symptoms have to arise within four weeks of the trauma (Scignar, 1996).

2.3.1 Assessment of PTSD/ASD

The Traumatic Principle Model is a useful model to assess PTSD/ASD¹ (Scignar, 1996). It comprises five areas:

- a) Vulnerability – this looks at the issue of predisposition and recognises issues such as social support, family history and personality variables. It is, however, important to remember that if the trauma is severe enough it can overwhelm anyone irrespective of whether they are vulnerable to PTSD or not (Lifton & Olson in Horowitz, 1999).
- b) Environmental stimulus – this involves a trauma which arises outside the body of the individual. It is important to remember that an external event is needed to precipitate PTSD.
- c) Perception of five senses – This refers to the neurological components of the event. The five senses inform the brain of the trauma.
- d) Cognitive awareness – before PTSD can develop, the trauma must be registered as being a threat.
- e) Zone of danger – the person has to be present at the scene of the trauma and be confronted with a situation of danger.

¹ Although it is important to distinguish between PTSD and ASD for treatment purposes, the same model can be used to assess both conditions.

2.3.2 Treatment of PTSD/ASD

In order for PTSD to be treated successfully a correct diagnosis has to be made as well as an analysis of how the trauma has impacted on the client (Scrignar, 1996).

Treatment can be effected thorough various models which are used to treat PTSD/ASD. These include international models (Herman 1992, Scrignar 1996, Harvey, 1998) and South African models of treatment. One of them was developed at the University of Witwatersrand (Hajiyannis &Robertson, 1999). These models appear to be based on similiar principles and practices which include:

a) Brief model

All the treatment models appear to advocate that trauma counselling is best done through a brief model of intervention (Ryan1994, Scott & Stradling 1994, Hajiyannis &Robertson 1999). Scott & Stradling (1994) cite a large number of studies that have found that 50% of clients are better after eight sessions and that clients don't really benefit after more than 26 sessions. Hajiyannis and Robertson (1999) recognise that in South Africa there is a large demand for trauma counselling, so services need to be cost effective. The number of sessions proposed by them range from two to fifteen sessions.

b) Psychoeducation

Psychoeducation is emphasised as an important aspect of treatment (Herman 1992, Scrignar 1996, Hajiyannis &Robertson, 1999). The counsellor educates the client about their symptoms because it is vital for the counsellor to reassure the client that their symptoms are expected and that they are not insane (Hajiyannis &Robertson, 1999).

c) Incorporates different approaches

Treatment models incorporate psychodynamic techniques as well as cognitive-behavioural approaches (Herman 1992, Scrignar 1996, Hajiyannis &Robertson, 1999, Appelt, 2003). The psychodynamic techniques used will differ depending on the personality of the client and how traumatised they are (Scrignar, 1996).

d) Encourages mastery

The counsellor focuses on coping strategies rather than on pathology (Herman 1992, Scrignar 1996). This involves assisting the client to use their coping strategies effectively. Ongoing support is required and the client is encouraged to mobilise their support systems (Hajiyannis & Robertson, 1999). The family, for example, is an integral part of the recovery process as well as an important means of gathering information and it is helpful to include them in treatment (Scrignar 1996). Unresolved issues exacerbate PTSD and the counsellor can assist the client by helping them to make decisions. The counsellor can also refer to relevant social agencies e.g. an unemployed client can be referred to a placement agency (Scrignar 1996).

e) Termination

With regards to PTSD there are no criteria for discharge from treatment.

Counselling is considered successful when clients return to their pretraumatic functioning (Scrignar, 1996). The final stage, which is where the client creates new meaning around the trauma, is only dealt with if the client raises the issue of ascribing new meaning to the trauma. The counsellor assists the client by using the client's belief system and culture (Hajiyannis & Robertson, 1999). In essence this phase is about assisting the client to become a survivor rather than remaining a victim. Judith Herman (1992:196) says this very poetically when she says that the client "has to reclaim their world".

One noticeable difference between the international models and the Witwatersrand model (Hajiyannis & Robertson, 1999) is that the international models view debriefing as separate from counselling whereas the latter views debriefing as the first stage in treatment.

In fact the first stage in the model proposed by Hajiyannis & Robertson (1999) is called Telling / Retelling the story. This model is also more helpful because despite the fact that it encourages flexibility it also gives the counsellor a sequential method to follow which acts as a useful guide. The purpose of treatment is to ensure that the client recovers from the traumatic event. It is therefore important to examine the issues around recovery from trauma.

2.4 Recovery from trauma

In terms of the literature the term “recovery” is poorly defined and criteria for recovery are seldom identified (Herman 1992, Everstine and Everstine 1993). Recovery does not happen in isolation and occurs only through relationships (Herman, 1992). There are four possible recoveries outcomes i.e. 1) *clients who received clinical help and recovered*, 2) *clients who have received clinical help and have not recovered*, 3) *clients who received no help and recovered* and 4) *clients who have received no help and did not recover* (Harvey 1998).

Harvey (1998) suggests that one needs to look at whether symptoms have been mastered, whether the client is able to assign new meaning to the trauma, the client is able to maintain relationships and whether the client is able to remember the trauma without being overwhelmed. Everstine and Everstine (1993) propose that recovering from trauma is similiar to recovering from grief. They state that the victim needs to go through different stages in order to overcome the trauma.

As counselling is based on a relationship between two people (Howe, 1993) it is necessary to examine the importance of this relationship.

2.5 Counselling relationship/ outcomes

The literature confirms that the counselling relationship is an integral part of treatment and largely determines whether treatment will be successful (Howe 1993, Mitchell 1993, Saunders 1999, Keijsers 2000, Torgalsboen 2001, Williams 2002).

A large amount of research has been conducted around how counsellors experience their work (Saunders 1999, O’ Leary 2000, Rowland 2000, Gehart &Lyle 2001) with there being fewer studies of clients’ perceptions of counselling (Keijsers 2000, Torgalsboen 2001, and Williams 2002).

I will not discuss the counsellors’ experience of their work here because this is not the focus of this study.

Saunders (1999:8) found that clients' emotional experiences have an impact on the outcome of counselling. He found that clients "rated session quality as greater when they felt less distressed and inhibited, when they perceived the therapist to be involved and not distracted, and when they perceived mutual affection with the therapist".

In a study conducted by Torgalsboen (2001), with schizophrenic patients, the patients rated their therapist's human qualities as the most important factor in treatment. Keijsers (2000) found that the therapist's levels of empathy play a vital role in therapy and the client's perception of the counsellor as being self-confident, skilled and active is also important.

A study conducted by Williams (2002) with clients who have had trauma counselling, confirmed the above findings. The clients rated the following characteristics/aspects of the counsellor as being important:

- a) The counsellor's human and ethical qualities, especially ensuring issues of confidentiality.**
- b) The ability to make the client feel safe and contained.**
- c) Being perceived as an expert and experienced in the field of trauma.**
- d) The counsellor focusing on psychoeducation i.e. meeting the needs of the client to understand their symptoms and normalising these symptoms.**

It is also evident that there are other factors which impact on the counselling process. These factors include gender issues and racial/ cultural differences between the counsellor and the client (Banks 1995, Hoff 1995, Schmidt 1996, Gehart & Lyle 2001).

Schmidt (1996) states that one way of dealing with cultural and racial issues in counselling is for the counsellor to provide a safe and open environment for clients. She adds that counsellors must not stereotype people from one racial group as being the same and the counsellor should get to know each individual client and accept them as individuals. Gehart and Lyle (2001) say that the relationship between the counsellor's gender and the counselling alliance is complex and counsellors need to be attuned to the issue of gender because it is a significant factor in treatment.

These findings were not supported by the research conducted by Williams (2002). However, it must be stated that this sample in this study was small.

Scott and Stradling (1994) state that after counselling, clients often have no symptoms, but they do feel that their world views have changed as a result of the trauma. For example, many clients report that they are more cautious. Furthermore Scott and Stradling (1994) say that it is important for the counsellor to prepare clients to accept that the trauma will change them. This refers to the issue of post-traumatic growth, which will now be discussed.

2.6 Post traumatic growth

The literature suggests that with the successful treatment of trauma victims can experience growth in other areas of their lives as well as recovering from the trauma (Wright 1991, Hybels-Steer 1995, Matsakis 1998, Lifton and Olson in Horowitz 1999). Wright, (1991: 23) states that “the Chinese interpretation of the word crisis describes it as an opportunity for change and personal development”. Matsakis (1998) says that there are a number of potential positive effects of trauma. These include a new appreciation of life, finding meaning in suffering and as a result of these developing closer bonds with people, developing empathy for people who have also suffered and developing new energy to tackle obstacles.

Everstine and Everstine (1993) say that trauma survivors see life differently because they have been forced to confront their own mortality. Survivors of trauma also develop more insight into themselves - for example learning how important and powerful their emotions are - and they become aware of hidden strengths which often they did not know they had (Matsakis, 1998). In fact Wright (1991) states that the location of these inner strengths is what allows the client to recover and experience post-traumatic growth.

Motivation arises from fundamental symbolisations which has to do with the person's images of life and what being alive means to the person. These symbolisations play a significant role in the person's day-to-day life and they also affect their ability for self-renewal and growth. Trauma can significantly interfere with these symbolisations (Lifton and Olson in Horowitz, 1999:216). This means that trauma can interfere with a person's ability to grow.

According to Solomons (1988), trauma can evoke underlying conflicts. Lifton and Olson in Horowitz (1999) argue that the survivor of trauma needs to find some meaning and significance in the trauma before the person can find meaning and significance in other areas of their life. Bass and Davis (1994) support this. They say that the survivors can truly heal only when they are willing to change aspects of themselves.

Mariann Hybels-Steer (1995) who herself is a survivor of trauma, discusses a number of ways in which survivors of trauma grow. She says that one of the most important changes for the survivor is the realisation that they have survived even though they have endured so much. Survivors also often evaluate their goals and values and all of them change forever irrespective of whether the changes are small or significant.

This author captures the essence of what surviving a trauma is like in her statement, “In our civilised culture where electricity abounds, we seldom have the experience of being in total darkness. There is always a light, somewhere in the night, anchoring us, guiding us. We seldom have the experience of being jolted awake, without warning, without preamble. Jolted and thrown out of bed, hearing what you are sure must be a freight train pushing through the earth under your very being. The lurching finally stops and there is a moment of relief. Then suddenly the sky brightens...” (1995:223).

The discussion of the importance of the counselling relationship and of the potential for clients to recover from their trauma highlights the need for counsellors to evaluate their work constantly so that they can ensure that they are meeting the needs of their clients.

2.7 Ongoing evaluation in social work

“Evaluation must be an integral dimension of social work and social care practice” (Shaw & Lishman, 1999:1). To put it more simply social workers know they must ask and answer the question “what is the use of what I am doing.”

A number of methods can be used to measure effectiveness of services and one way of doing this is to look at how clients see the service (Cheetham, 1994:5).

Baer (2001) argues that current trends in mental health require effective practice and accountability. She advocates the training of social workers to evaluate their work constantly and suggests the use of the Vanderbilt Psychotherapy Scale (VPPS).

The VPPS evaluates the process of counselling because it is based on the philosophy that the client's and social worker's attitudes and behaviour impact on the counselling process. It consists of various subscales and is used by external observers such as clients and supervisors. The article also mentions other instruments which can be used to evaluate the therapeutic relationship e.g. The Working Alliance Inventory.

It is necessary at this point to clarify the theoretical approach which underpins this study. This is the theoretical approach which is used at The Trauma Centre.

2.8 The Trauma Centre's approach

The Trauma Centre uses a counselling approach which can be described as an integrated approach because it combines elements from different theoretical frameworks as discussed by Dryden (1992), Comas-Diaz (1994) and Corey (1996).

Dryden (1992:6) states there are various methods of integration and the method used by the Trauma Centre appears to be what she refers to as theoretical integration i.e. it integrates one or more theories in the hope that "the sum will be better than its parts" and that the integrated approach will give rise to new practices. The different frameworks used by the Trauma Centre will be discussed below. I will first discuss why an integrated approach is appropriate in the context of trauma counseling.

2.8.1 Motivation for an Integrated Approach

A number of theorists argue the importance of using an integrated approach (Dryden 1992, Comas-Diaz 1994, Corey 1996). Comas-Diaz (1994:287) states that "the need for integration of numerous psychotherapeutic techniques is emerging as a trend in the delivery of mental health services".

Another advantage of an integrated approach is that it encourages counsellors to examine different theoretical frameworks and to merge the aspects which they think will be most beneficial to clients (Dryden 1992, Corey 1996).

Comas-Diaz (1994) agrees with this and argues that clinicians need to use this type of approach because its flexibility ensures that the counsellor uses a variety of techniques to help the client and this promotes more effective healing. Furthermore this type of approach also means that traditional models of counselling are combined with sociocultural factors. This implies that in this type of approach issues of gender, race and culture are acknowledged. In the context of the Trauma Centre this is vital owing to the diversity of clients.

The authors, however, caution that there are disadvantages to an integrated approach. These include: a) counsellors may not be adequately trained in different theories, b) there has been limited research to establish the efficacy of integrated approaches and c) counsellors often have different understanding of therapeutic concepts and this may lead to confusion amongst clinicians (Dryden 1992, Corey 1996).

I now discuss the different theoretical frameworks which make up the integrated approach of the Trauma Centre. Appelt (2003) conducted research to clarify the theoretical approach of the centre. Her study identified the following theories:

2.8.2. Crisis intervention

Crisis Intervention is a vital aspect of the Trauma Centre's work because a traumatic event can be defined as a crisis because of its capacity to disrupt the individual's life (Golan 1981, Mitchell 1993, Murgatroyd & Woolfe 1993, Parsons & Wick 1994, Hoff 1995, Roberts 1995, Leiper 2001). Crisis intervention is therefore a relevant framework in the treatment of trauma.

Crisis Intervention was developed in the 1960s and an integral assumption in this approach is that a crisis plays a significant if not the most significant part in the development of a psychiatric disorder (Golan 1981, Mitchell 1993).

There are two types of crises: 1) *developmental crises, which are linked to life stages*, and 2) *coincidental crises, which are unrelated to any particular life stage* (Wright, 1991).

Crisis Intervention is a short-term approach, which focuses on the resolution of the crisis through the “use of personal, social and environmental resources” (Hoff, 1995: 4). Cumming and Cumming in Golan (1981) note that all crises elicit a similar pattern of response i.e.1) *it firstly results in physiological and psychological distress*, 2) *the client has a painful preoccupation with the past* and then finally *the person experiences a period of readjustment and mobilisation*.

The goals of crisis intervention include: “ 1) Stabilisation i.e. cessation of escalating distress, 2) Mitigation of acute signs and symptoms of distress, dysfunction or impairment, 3) Restoration of adaptive independent functioning and 4) Facilitation of access to a higher level of care (Everly & Mitchell in Appelt, 2003:4). Establishing rapport with the client is the counsellor’s first priority; in fact rapport and effective communication are vital, ongoing aspects of successful crisis intervention.

Crisis counsellors need to know how to deal with clients who are distressed e.g. they must avoid asking why and they must make the client feel understood (Murgatroyd & Woolfe 1993, Hoff 1995, Leiper 2001). A thorough assessment is important and this is followed by a clear intervention plan. The client and counsellor agree on a plan of action, which forms the service contract, and the active involvement of the client is a prerequisite for treatment to be successful (Parson & Wicks 1994, Hoff 1995).

There are a number of crisis intervention strategies such as: 1) *encouraging the expression of feelings*, 2) *assisting the client to gain an understanding of the trauma* and 3) *assisting the client with exploring alternative ways of coping with the trauma* (Hoff 1995, Roberts 1995).

2.8.3 Brief psychodynamic psychotherapy

A fundamental principle in brief psychodynamic psychotherapy is that the treatment must have a central theme/issue as its focus (Budman & Gurman 1988, Shalev et al, 2000, Appelt 2003).

Psychodynamic therapy with trauma victims focuses on the here and now and deals with developmental issues only as they emerge. Previous losses or traumas are used to explore associations with the current trauma. These associations may be conscious or unconscious (Budman & Gurman 1988, Shalev et al 2000).

Current traumas are seen as evoking previous traumas and the aim of intervention is to elicit the meanings of these traumas and to facilitate their resolution. In fact one of the main goals of counselling is to use the traumatic event to facilitate some form of personal growth (Solomons 1988, Shalev et al 2000). It is hoped that the person is able to move beyond the trauma despite acknowledging and remembering the event (Stephen O' Brien, 1998).

Cabrera (2003) also supports this view and further argues that the clients need a place within which they can deal with their pain. She adds that people need to be allowed to express their other pain besides the trauma as well, so that the counsellor gets what she calls an 'inventory of wounds'. Cabrera (2003) argues that the understanding of the 'inventory of wounds' allows the counsellor to facilitate the healing of the client on many levels.

When working with trauma, the psychodynamic counsellor's primary objective is to explore what personal meaning the trauma has for the client. The counsellor pays special attention to the impact of the trauma on the self-image of the client as well as its effect on the client's views of others (Stephen O' Brien, 1998).

Budman & Gurman (1988) cite a number of authors : Garfield 1978, Langsley 1978, and Petevi 1979, who suggest that in this approach treatment usually continues for less than three months with the average number of sessions being between three and eight. These findings are supported by Williams (2002).

In order to create a balance between the traumatic memories, the external demands which the client has to meet and the client's own needs, the counsellor facilitates the working through of the client's repressed memories.

The counsellor remains neutral and allows the client to project feeling about their significant others onto him/her. The client gains insight by exploring these feelings and this helps with symptom alleviation (Friedman in Appelt, 2003).

As such the psychodynamic view “differs from cognitive and behavioural approaches in that it incorporates a broader range of issues and encourages more individualised treatment” (Shalev et al, 2000:348).

The psychodynamic approach, on review of the literature, is a valuable approach in trauma counselling because it not only demands that the treatment should have a focus but it also provides for the possibility of resolving underlying conflicts. In doing so it allows the counsellor to assist the client to resolve the trauma as well as achieving post-traumatic growth. As discussed above, trauma counselling is best done through a brief model of intervention, which is another reason why the psychodynamic approach is indicated in the treatment of trauma.

2.8.4 Systemic Integrated psychotherapy

Systemic Integrated Psychotherapy can be defined as being based on the integration of theories, strategies, values and interventions within a therapeutic relationship, which is based on a systems approach. This approach is a deliberate integration of theories which are relevant to the particular context (in this case trauma counselling) rather than an ad hoc integration. There are four domains of variation in this approach (Dryden, 1992):

- a) Client variation- the client is seen as a system on his/her own consisting of sub-systems e.g. the client has a value system as well as an autonomic system.
- b) Counsellor variation – counsellors are human too and have their own styles and personalities. He/ she also has skills and knowledge which will impact on the counselling process. The counsellor and the client also combine to form a system.

- c) Variation over time – The counselling relationship occurs over time. People change and develop as time passes and the relationship between the counsellor and client will thus evolve over time. When one works within a systemic appreciation of the importance of time in counselling, counselling can be viewed as going back to the past, coming to the present and moving to the future (Dryden, 1992).
- d) Variation in environment - Not only is the physical environment in which the counselling occurs important, but the counsellor also needs to be aware of how changes in the environment can impact on a client.

This is especially relevant as far as the client's family is concerned. In The Trauma Centre context one immediately thinks of people who live/work in gang-ridden areas and how significantly their environment impacts on their safety. This approach views the client holistically i.e. it takes into account the person's physiological, emotional, spiritual, intellectual, cultural and interpersonal dimensions (Dryden, 1992).

2.8.5 Narrative therapy

Narrative therapy is a fundamental aspect of the counselling at the Trauma Centre and the literature supports the use of narrative therapy with trauma victims (Howe 1993, Corey 1996, Howard & Wirtz 1999, Crossley 2000, Besley 2001, Appelt 2003).

Narrative therapy was developed in Australasia by Micheal White and David Epsen and is based on the belief that human psychology is structured in a narrative way i.e. that human beings combine events to form a 'story' (Corey 1996, Crossley 2000, Besley, 2001).

Crossley (2000) says that the aim of the 'story' is to give a meaningful, organised account of the person's experiences. Howe (1993) proposes that anything that is not structured in a narrative manner is forgotten. The 'story' seems to be particularly important when people have been through a traumatic experience. Part of the healing is to help them make sense of the event i.e. create a 'story'. Crossley (2000: 56) explains this as when a person experiences a traumatic event they lose some of the connections in their 'story'. She describes this as "narrative wreckage".

With trauma, the emphasis is not on what could have happened or on reliving the trauma, but rather on creating a rich 'story' of the client's experiences and life. This assists the client with gaining deep insight into his or her own identity. This in turn allows the client to gain an understanding of their reactions to trauma and how this relates to their beliefs and identity (Crossley, 2000).

Narrative therapy is useful for working with trauma survivors because it emphasises the issue of power in the counselling relationship. Trauma survivors have all had the experience of being disempowered and feeling powerless (Howard & Wirtz, 1999). Narrative therapy is based on various principles which decreases the counsellor's power and increases the client's power - for example seeing the client as the expert in their life. These principles allow the client to take back control of their life, which is a vital part of recovery (Howard & Wirtz, 1999).

2.8.6 The cognitive approach

If one refers back to the symptoms of PTSD/ASD as outlined by Scrignar (1996) it is evident that trauma affects the cognitions of the victim. The cognitive approach is therefore an important approach in the treatment of trauma.

Aaron Beck in Dattilio and Freeman (1992) developed this approach and it is a short-term, structured approach. Active collaboration between the counsellor and client is used to achieve treatment goals (Dattilio & Freeman 1992, Kaplan & Sadock 1991, Corey 1996). This approach is based on the premise that the way in which a person structures his/her experiences will determine how the person feels or behaves (Dattilio & Freeman, 1992). There are various techniques used in this approach as cited by Appelt (2003:10):

- a) Exposure therapy- this includes exposing the client to traumatic stimuli through imagery and In-vivo exposure where the client confronts the scene of the trauma.
- b) Cognitive restructuring - this focuses on getting the client to learn new thoughts around the trauma so that he/she can regain their coping skills.

- c) Cognitive Processing Therapy – this focusses on the emotional and cognitive sequelae of trauma in order to help the client to progress beyond inappropriate feelings and distorted cognitions.
- d) Stress Inoculation Training – this includes stress management techniques which aim to increase the coping mechanisms of the client.

The cognitive approach also emphasises the counselling relationship as being vital and the counsellor is seen as needing to be warm, empathic and skilled (Dattilio & Freeman 1992). An important aspect of treatment is that the counsellor must provide the client with a sense of safety and support (Kaplan & Sadock 1991, Corey 1996). Hagiannis & Robertson (1999) state that clients usually struggle with self-blame and they have many questions around their actions and possible alternative actions. The counsellor explores these alternatives and usually the client realises that their self-blame is irrational.

Corey (1996) highlights some of the criticisms which have been directed at the cognitive approach. These criticisms include: 1) *the approach is too simplistic because of its focus on positive thinking*, 2) *it does not view the client's emotions as an integral part of treatment*, 3) *cognitive therapy is seen as denying the significance of the client's history* and 4) *it focuses on symptoms without examining the underlying causes of these symptoms*.

Dattilio and Freeman (1992) however dispute these criticisms by arguing that despite the fact that the cognitive approach seeks simple solutions, the practice of it is not simple. This approach does not focus on the client's history but it does recognise that the person is often a product of his/her past.

An integrated approach recognises that the relationship between the counsellor and the client is an integral part of treatment. The counsellor works at different levels with the client i.e. emotional, behavioural, cognitive and systemic (Dryden 1992, Comas-Diaz 1994, and Corey 1996).

The importance of this relationship has been discussed above but there are elements of the counselling relationship that need to be clarified. These elements include ethics and the importance of supervision. I will now discuss these two elements in more detail.

2.8.7 The counselling relationship

Power imbalances is especially relevant in trauma counselling because the fact that the clients' have been involved in a traumatic incident implies that they have experienced an abuse of power by other individuals and that they were disempowered in the process.

Social work ethics focus on the relationship between the client and counsellor and it takes into account the context in which practice is occurring. There are four basic principles to the profession: *1) The client's right to self-determination, 2) the promotion of the clients' well-being, 3) each client being equal especially with regard to obtaining the most effective service and 4) distributive justice which is linked to how resources are distributed* (South African Council of Social Service Professions, 1997). All the counsellors at The Trauma Centre are registered with a professional body and they subscribe to their profession's code of ethics.

Another important aspect to trauma counselling is supervision. According to Henry Hensley (2002) many theorists have written about the importance of supervision. In fact supervision has always played an integral role in the training of social workers. Kadushin in Henry Hensley (2002), one of the pioneers in the field of supervision argued that supervision has three main functions viz. administrative, educational and supportive. Another important function of supervision is that it prevents burnout.

Kadushin argues that the nature of the supervisory relationship that the counsellor has will affect the type of relationship that the counsellor has with his/her clients. A study conducted by Henry Hensley (2002) concluded that counsellors found supervision played an integral role in the success of intervention with clients.

Freitas (2002) cites various studies (Dodenhoff 1981, Sandell 1985, Ilberg 1991, Harkness 1995, Harkness 1997) that show that supervision does have a positive impact on the outcome of the counselling relationship.

2.9 Memory and stories

According to Plummer (2001) the issue of memory is an important one when it comes to people telling their stories. He also provides a valuable framework in assessing memory as a factor when it comes to people and their narratives.

I have discussed the importance of narratives in the treatment of trauma and Plummer (2001) distinguishes between psychological memory i.e. what the person can recall and narrative memory i.e. that memories consist of our most frequently narrated stories. There is also a third kind of memory i.e. collective memory which moves beyond the individual and includes a societal framework for how the story should be told. Plummer (2001) further argues that memory is not just a psychological entity but it is shaped by setting, society and culture.

This then raises the issue of how we know when people who are telling their story are telling the truth. In other words how do we differentiate between a 'good' and 'bad' story. It is, however, important to acknowledge that all stories are subjective - but that this does not mean that they are weak. There are various ways of analysing stories which includes the approach that I would argue for. It is suggested that one can look at two factors when looking at how truthful stories are. These factors are: 1) sincerity and 2) authenticity. In fact when people tell stories these stories become 'ethical tales' because they show the "choices people have faced and how they dealt with them" (Plummer, 2001:250-252).

In terms of the context of this study it was necessary to assess how sincere and authentic respondents were when telling their stories because they had terminated counselling prior to the research interview and I was concerned about the accuracy of their memory of counselling.

Furthermore the primary purpose of the study was to determine how the respondents experienced their counselling and in order for me to gain a true reflection of their feelings about their counselling experience, it was also important that they be sincere in their feedback.

Conclusion

In conclusion it is evident from the literature that a traumatic event is capable of disrupting any individual's life irrespective of whether he/she is vulnerable to trauma or not. One has, however to recognise that there are factors which can predispose a person to trauma. There is a distinction between Post-Traumatic Stress Disorder and Acute Stress Disorder and a thorough assessment and diagnosis should be made before treatment can commence.

There has been a debate about the efficacy of debriefing. There are similarities between the principles of international and national models of treatment of PTSD/ASD. It is evident from this review that trauma counselling is best done through a short-term model of intervention.

A significant aspect of treatment is the fact that individuals can experience emotional/psychological growth as a result of a traumatic event and subsequent trauma counselling. Various authors have described what the nature of these changes can be and that post-traumatic growth occurs frequently. The most important factor in terms of the outcome of counselling appears to be the relationship between the counsellor and the client. A number of studies describe this. Gender and culture also appear to have a significant impact on the counselling relationship.

It is important for counsellors to evaluate their work on an ongoing basis. The Trauma Centre uses an integrated approach to counselling and motivation for an integrated approach was provided. This approach combines elements from various theoretical frameworks and therefore a brief discussion of each framework was presented. I also discussed the importance of ethics in the counselling relationship and the supervision of counsellors in ensuring that clients are treated appropriately.

It is, however, important to note that all the approaches emphasise the significance of the counselling relationship. In fact they all contain guidelines for how the counsellor has to engage with their clients and what the nature of the relationship should be.

Chapter Three

Presentation of results

This chapter presents the results of this research. The study yielded both qualitative and quantitative results because it utilised both research designs. The qualitative results are discussed by means of different themes and quotes from the interviews are included to illustrate these themes. The quantitative results are presented by means of graphs. Tables illustrating the demographic details of the sample, the nature of the traumatic events experienced by the participants, the sources of referral to the Centre and the duration of time between the termination of counselling and the research interview will be presented first.

3.1 Presentation of results

I will now present the results of the study and I will firstly illustrate the demographics of the sample.

Table no. 3.1 - Demographic details of the sample

Age range	Number of participants
60-69	1
50-59	4
40-49	2
30-39	7
20-29	6

The subjects' age ranges from 21 years to 62 years with the majority of the respondents falling into the 30-39 category.

Table no. 3.2- Gender distribution of the sample

Gender	Number of participants
Male	7
Female	13

Considerably more females than males participated in this study. This is not entirely consistent with the general population of the Centre² as well as that of the Western Cape where there are only slightly more females than males. Eighteen of the twenty respondents were Christian and the remainder was Muslim. They also worked in various occupational sectors ranging from security management to domestic work. One of the respondents was a student. The majority of the respondents spoke Afrikaans as their first language, seven of the respondents were English-speaking, three were Xhosa-speaking and one was Zulu-speaking.

Table no. 3.3- Nature of the traumatic event

Traumatic event	Number of participants
Hijacking (perpetrator/s forcibly removed the respondents from their car and drove away with the car)	5
Robbery (theft with the use of force)	4
Armed Robbery (Robbery with the use of a weapon)	3
Mugging (snatching of a bag, without force)	2
Housebreaking and armed robbery	2
Assault and armed robbery	2
Housebreaking and assault	1
Attempted hijacking	1

The respondents were all direct victims of a traumatic incident and all of their assailants were unknown to them. Weapons were used in fourteen of the twenty cases including the hijackings, attempted hijacking and the housebreaking and assault case. Guns were the weapons of choice in thirteen of the fourteen. The fourteenth perpetrator used a knife.

² In 2003 360 females were seen as compared to 326 males.

Table no. 3.4- Source of referral to The Trauma Centre

Referral Source	Number of participants
Employer	6
Friend	5
Family member	3
Community clinic	2
Self-referral	1
School psychologist	1
Community organization	1
South African Police	1

From the table, it is evident that the Centre receives referrals from various referral sources and that the respondents communicated their need for support to a variety of people. The fact that six of the twenty referrals came from the clients' employers indicates that there is a growing awareness amongst employers of the importance of the mental health of their employees and the impact that trauma could have on this.

Table no. 3.5- Time elapsed since counselling

Time	Number of participants
Six months	4
Five months	3
Four months	2
Three months	1
Two months	10

All of the respondents had completed counselling in the past six months prior to the interview. Half of the respondents had completed counselling two months prior to the interview. The longest period of time between the termination of counselling and the research interview was six months.

3.2 Presentation of qualitative results

The data collected will be presented in the form of categories which emerged from the respondents' accounts in the interview.

3.2.1 Emotions during and after the incident

The respondents described a range of intense emotions which included:

a) Fear

Fifteen of the twenty respondents spontaneously reported that they felt fear during and after the incident. One person said, **"It was incredible the level of fear that I have never experienced and hopefully will never experience again."** whilst another said, **"Even if I just walked over the road I was scared yes because I was quite jumpy."**

They generally thought that they were going to die during the event and the following quotes are examples of this. **"I keep on feeling the gun against my head, I keep on feeling these things and I feel that it was a divine intervention that prevented them from killing me"** and **"Oh Lord please just let me live for my daughter and my grandson. Please Lord save me."**

Respondents also felt unsafe everywhere after the incident with one person saying, **"I was scared and I thought to myself a person is not safe, you know, whether it's in your house or outside, or even walking, you know to the shop or whatever. And I was just so very scared and afraid you know...."** One of the female respondents said, **"I used to run ten times to the window to see who was driving past, who is outside?"**

b) Anger

The presence of anger and irritation was described by eight of the respondents and this anger was directed at various people. There was anger at the perpetrators.

“I was cross that they invaded my office; I was just so very cross. How could they do it to me?” Another respondent said, **“I was very angry. I was with my son and this person was so cold to actually expose this during my son’s presence”** (she meant that the perpetrator could expose her son to the event).

There was also anger at witnesses who did not intervene. **“I hated the people that were on the opposite side of the road because nobody stopped. They heard me shouting and crying.”** There was anger at the justice system. **“I had a lot of anger. Not just for the guys but also for the system because it seems they just don’t care. You see it happens to zillions of people. You didn’t even call to give me a case number...”** There was also anger towards God. **“I don’t believe in God any longer. I didn’t want to go to church. Why? There are millions of people much richer than I was. Why me?”**

c) Survivor guilt

Four respondents felt as if they were in some way responsible for what had happened to them when they first presented for counselling.

One person said **“I wasted time in the morning and stood up late. And probably that, if I hadn’t done that I probably would have been earlier at work and it wouldn’t have happened then.”** Another respondent said, **“I was so cross with myself letting these gentlemen in, well dressed gentlemen.”** and another added, **“I hated myself for wearing what I did (she felt she was dressed provocatively). I should have seen it coming (the attack).”**

d) Anxiety and depression

Anxiety and depression seems to have been common. Over a third of the respondents (seven) reported to have felt anxious or depressed. One person said, **“I didn’t want to speak to people. I don’t want to speak to my daughter. I don’t want people coming over, going out. This will be the second, third week I’d be dressing like this wearing tracksuits...”** (The client was used to dressing more formally and she felt that she had looked untidy in the tracksuits). Another respondent said, **“I was moody, anxious. What else, angry, sad.”**

e) Shock

All the respondents reported to have felt shocked but two in particular stated that their shock was so great that they felt numb. One respondent said, **“I was very shocked. Even though I was expecting something like this to happen because in our area they have been hijacking people a lot.”** Another added, **“It wasn’t like I felt anything..”**

Five respondents reported that it felt as if what was happening to them was unreal **“And I thought to myself is this really happening to me. It can’t be real.”** Another respondent said, **“I thought this is not me, it looks as if I’m standing somewhere and I’m looking over this like a story.”** One person stated that their main feeling at the time was one of confusion. **“Confusion, I just felt you know so many different emotions...”**

f) Helplessness

There was generally a sense amongst the respondents that they were helpless but four of them spontaneously spoke about how helpless they felt and how distressing this was for them.

One respondent said, **“All I said was please Lord don’t let them shoot me and then I was helpless.”** and another said, **“Well, the worst was the helplessness. I couldn’t do anything about that at that stage. I’m always a fighter but I couldn’t fight. I was helpless.”**

3.2.2 The appointment system at the Centre

The appointment system was discussed in chapter one. Nineteen of the twenty respondents felt that they preferred having an appointment versus coming to the Centre as a walk-in and potentially waiting to be seen. The twentieth person was ambivalent about this and did not give a definite answer. There were various reasons for respondents preferring to have definite appointments:

a) Two people said they were not sure what to do when they arrived and being seen immediately helped to alleviate this. One person said, **“I wasn’t sure on what to do when I got there, so I asked for (counsellor’s name) when I came in..”**

b) Ten of the nineteen said that waiting to be seen would have increased their anxiety for example, **“I think it’s better by appointment because then you feel someone is expecting you. I can imagine sitting there and waiting anxiously. The person that you expect to see is not aware of you, you’re just rocking up there. That would obviously make me more nervous.”** One respondent said, **“Waiting wouldn’t have been a very pleasant experience because I needed that attention now, you know what I mean.”**

c) One respondent said that she did not want to have to come into contact with other distressed clients because this would have upset her and therefore having an appointment meant that she could arrive just before her appointment and be seen immediately. She said **“I don’t want to sit and wait and listen to everybody. There was one gentleman that was so distraught and it actually upset me.”**

d) Two respondents believed that an appointment system is more organised and professional with the one saying, **“I think that an appointment system would probably work out better for the Centre and the client. Just in terms of logistics, you know, because of some days you might like have nobody and other days 500 people. It just organises things better.”**

e) One person also said that it was easier to negotiate time off from work because she has a definite appointment. She said, **“Well since I am working and I don’t have any spare time, it was good for me to have an appointment.”**

f) Three respondents could not give specific reasons as to why they felt an appointment system is better than a walk-in system.

3.2.3 The counselling process

3.2.3.1 Duration of treatment and reasons for termination

The average number of sessions attended by clients was 4.7 sessions. Twelve of the respondents decided to terminate counselling because they felt that their condition had improved, e.g. **“I felt fantastic.”**

In four cases the counsellor suggested that the client was ready to terminate, **“She said I don’t have to come back.”** In another four cases it was a joint decision, **“It was like a mutual agreement because you know we looked at everything, we looked at the progress and decided it was just not necessary to go on any longer.”**

Eight clients were told that they could return for counselling if they needed to at a later stage and all of them said that this was reassuring to them. The one respondent said, **“She said if I needed help I could phone her. That’s a great feeling. There’s someone out there that will listen if I have a problem.”** Another respondent said, **“She told me that in future I can phone her. I actually feel happy about it, knowing that I can speak to somebody.”**

3.2.3.2 What was helpful about the counselling process?

All the respondents found the counselling process to be beneficial. The following aspects of counselling were identified as being beneficial:

a) Support and being listened to

All the respondents found the experience of feeling supported as vital and three of them emphasised that the most helpful aspect of counselling was that they felt understood. **“She validated what I said and made sure that she told me that she believed what I was saying and understood.”**

Furthermore, eight of the twenty respondents found the experience that they were listened to as being very helpful. One said, **“She just listened. That is what she did.”** Another respondent said, **“I think it was definitely the woman who helped me. I relayed to her what had happened and she entered in what I had went through.”**

b) Someone to talk to

Seven of the sample felt that the fact that they could talk to their counsellor about the event and their distress which was very therapeutic and they emphasised the value of debriefing.

“...It was nice to have someone ask me the little details, everything you know and to question what happened and I think it is important when something traumatic happens, it is a very visual thing and it was important for my counsellor to ask me lots of questions because people don’t generally ask you the little questions and you need to talk about every aspect to deal with it.”

They felt that they could not talk to other people with four respondents feeling that they needed to protect their families from their distress **“If you speak to your husband you have reservations. You speak to your children you’ve got reservations. But if you speak to a stranger you can open up.”** One of the male respondents said that he could not talk to his wife because, **“...when she heard about it she was very emotional so I didn’t want to affect her more.”**

Three people felt that other people did not understand what they needed at the time for example, they needed to retell their story which is what counselling provides for. **“You know, because everybody is like, oh oh I’m sorry, but I mean they don’t really want to hear all the details 150 times.”**

c) Psycho-education

More than a third of the respondents (8) emphasised the importance of being educated about the human reactions to trauma. These respondents reported that they found it reassuring to know that their reactions were common and that there was nothing wrong with them. It was important that the counsellor explained what the common symptoms of PTSD/ASD for example insomnia, flashbacks, headaches and lack of appetite. This was reassuring because the majority thought that they were becoming psychotic. **“She gave me the pamphlet that I could read about it and make me understand that the way I’m feeling is quite normal and that there is nothing abnormal about it. That is the way, that is the reaction that I will have and that helped me a lot because I thought I was going mad.”**

A further five respondents reported that the fact that they were informed of coping strategies which they could use to deal with their distress was very beneficial **“She talked a lot about the whole thing, encouraging me how to face it. She taught me so much and all these things I practised them and I felt much better.”**

c) Being assisted with recovery

Eight of the respondents spontaneously reported that they felt that they recovered from the trauma as a direct result of counselling, one respondent said, **“It helped me a lot.”** Another respondent said, **“The therapy I got is amazing, I see him (the perpetrator) everyday and it doesn’t bother me anymore.”** Three respondents highlighted the debriefing session and the fact that they could confront the event in counselling as vital to their recovery **“Ja, I think if I didn’t have that I would probably still be in that process but at least I could relate the situation and what they told me and that was the biggest help.”**

d) Confidentiality

Two respondents said that the fact that the sessions were confidential helped them to feel secure and therefore they felt that they could deal with the necessary issues **“If you speak and it was in confidence then you feel you can open up.”**

e) Experts in trauma management

It appears from the results that it is important for counsellors to be experienced in the field of trauma management and to present themselves as skilled and knowledgeable to clients. Eight of the respondents found this to be an important aspect of counselling. One respondent said, **“The reason why I came here was because I thought well they must actually deal with terrible, terrible violent crimes which happened to me and I don’t see the psychologists in the southern suburbs or wherever dealing with traumas in the same way. I think they are used to less traumatic events like husbands cheating on wives and I don’t think they would be equipped to deal with what happened to me.”**

g) A safe and contained space

Five respondents experienced the containment of their counselling as crucial to their recovery. **“It was just like it gave me a structured place to really sit and go through the event and say what bothered me and see ways of you know life beyond fear or it was just giving terms until you start the healing process.”**

Along with this was the issue of, **“I was very aware of my surroundings and always being safe.”**

h) Other aspects of the service

Two respondents said that coming for counselling to the Centre was helpful partly because they did not have to worry about the issue of payment. Six of them said that the Centre’s physical environment contributed to them having a positive counselling experience. This included **“Even the receptionist, makes you feel that you are no victim,”** and **“The excellent service and I didn’t have to pay a fee.”**

The physical environment was also important and one respondent said, **“I must add the surroundings are pleasant you know it is not like an old ramshackled building with paint peeling off the walls which would have not appealed to me no matter how good they are inside.”** A sense of security was also important with one respondent saying, **“There was a safety gate. I approached the security officer and he assisted me in a nice manner.”**

3.2.3.3 What was not helpful about the counselling process?

All the respondents found the counselling to be completely beneficial and none of them found anything about it to be unhelpful.

One respondent however, said that he was referred to the aromatherapist and he did not find this helpful because he had **“said to her that my shoulder was injured, but she worked more on my back”**. He added **“I think the person who does aromatherapy must listen to the person concerned to find out really where the hurt is and work on it.”** This ties in with the category of the importance for the respondents to have felt listened to.

Three of the respondents contacted other counsellors before coming to the Trauma Centre. One of them did not make an appointment when she heard what this counsellor's fees were. She was one of the two people who said that not having to pay fees was beneficial because she was unable to afford fees. The other two saw another counsellor once and both of them were unhappy with the service they received. They in fact spoke about these sessions to illustrate how helpful the service at the Centre was. They raised the following concerns:

- a) The other counsellor showed a lack of concern or interest in them. One said **"I have just been talking to him and he first asked me if I was insured."** and the other one said **"She looked uninterested, hardly took notes."**
- b) They received no assistance in terms of support or guidance **"I spent an hour telling him what happened to me and he said, "ok that's it."**
- c) The other counsellor was not experienced in trauma management **"I must speak to someone who can deal with trauma. He obviously wasn't a trauma specialist."**
- d) The physical environment was an issue especially for one participant. She said, **"she had people walking in and out of her office whilst I was crying. I was quite embarrassed. Everything was just filthy in the office."**

3.2.4 The characteristics of the counsellor

3.2.4.1 The helpful characteristics of the counsellor

The counsellor's human qualities were identified as the most helpful characteristics for the subjects. The participants identified the following qualities as important:

- a) Sixty percent of the sample identified the counsellor being caring as the most helpful characteristic of the counsellor. **"Her warmth and caring, she validated me."**

- b) Along with this, just fewer than fifty percent reported that the counsellor understanding them was also vital. **“She entered in the actual happening and that is a characteristic that I found in her, that she felt for me. Yes oh yes, she really understood what I went through.”**
- c) Eight of the respondents reported that their counsellor was accepting of them. One said, **“She accepted me. She never, she didn’t say ok it’s fine now. She never pushed me to say, give more.”**
- d) Five respondents found the counsellor’s calm and containing manner to be very positive. **“You know I was discussing things that obviously affected me deeply and emotionally, her calmness I felt was like a stabilising influence.”**
- e) Three respondents said that the counsellor’s body language was important to them. One client said, **“Her posture, her tone of voice, I immediately felt comfortable.”**
- f) One respondent said that the sincerity of her counsellor was vital to her feeling that counselling could assist her recovery from the trauma.

3.2.4.2 The unhelpful characteristics of the counsellor

Only one respondent reported that there was something about his counsellor which was not helpful. He found the fact that she would get up in the session to pour water for herself very distracting and he said, **“I mean what made me nervous was when she would get up and then she goes to get water and I am wondering what she is thinking.”**

3.2.5 The impact of gender, religion and race

3.2.5.1 The impact of religion or race

Religion and race did not seem to be significant factors in treatment with only ten percent of the sample having felt that culture/race was significant in their counselling.

One respondent reported that the fact that his counsellor of the same religious and racial group was helpful only because a religious issue arose during his counselling and he felt that she understood this. He said, **“The culture was not really an issue but while we were speaking there was a religion thing that came up and that made feel comfortable that she was from the same religion.”** The other person, however, said that it would have been an issue for her if her counsellor had been of the same race group as her assailants. In this instance the counsellor was of the same race group as the respondent.

3.2.5.2 The impact of gender

It should be noted that all of the respondents had female counsellors. This is consistent with the Centre’s population because the majority of counsellors at the Centre are female. More than half of the sample reported that the gender of their counsellor impacted on their experience of counselling.

Three of the eleven participants (all female) who felt that gender did play a role in their counselling, said that they preferred a female counsellor because their assailants were male and they would have had difficulty trusting a male counsellor. **“It’s a man that did it, so I wouldn’t have wanted to speak to a man, to tell a man what another man did.”**

The other eight (five females and three males) felt that a female counsellor was more understanding and sensitive than a male counsellor would be. **“I was so much comfortable with a woman, she knows my angles, she knows how I feel.”** Three of the seven males in the sample said that they would feel more comfortable with a female counsellor.

They felt that a female would be more nurturing. **“She was like a mother- always giving support. I don’t know if a man would have given you that. A man just wants to be a man.”** They felt that they could not be vulnerable with a man. **“I would have had to be strong with a man.”**

Nine respondents who felt that the gender of their counsellor was not a significant issue for them said that this was because they needed help at the time and also because they were seeing a professional counsellor.

One respondent captured this when he said **“Well at that stage I was traumatised, whether it was a male or female I think it would have had the same effect, because they are professional people.”**

3.2.6 The resolution of other issues

Only two of the respondents did not deal with other issues other than the traumatic event in their sessions. The most common issues dealt with by the other respondents were:

Table no.6 - Other issues dealt with in counselling

Types of issues dealt with in counselling	Number of respondents
Family/relationship issues	13
Unresolved childhood issues	6
Previous losses	4
Employment issues	3
Substance abuse	1

Quotes illustrating these other issues

- 1) **“My daughter had an even worse thing in my house when she was fourteen. I think as a mother I didn’t understand.”**
- 2) **“My parents had a very bad, bad divorce. You know so it was a very dysfunctional family and we discussed that.”**
- 3) **“She took me back to my past and we spoke about childhood issues.”**
- 4) **“You know my brother died in a car accident when he was 21 years and we discussed that as well as the attack.”**
- 5) **“There were issues that I was also dealing with at the time in my personal life, she was of great help to me.”**
- 6) **“We ended up talking more like my work environment, I told her what I was doing and my word is not taken and you know.”**
- 7) **“So many issues came out, even issues with the church.”**
- 8) **“We went back to the past, where I went wrong.”**

- 9) **“I talked about other problems as well. I told that lady about what happened to me before because I had just lost my brother.”**
- 10) **“We spoke about what is happening in my life.”**

Of the eighteen, more than half had not been aware that the issues they eventually discussed in counselling were impacting on their current lives. **“So many other issues came out, even issues with the church that I didn’t know. Once she started talking to me all these things came out.”** Another respondent said, **“I never knew I had a problem with the two children.”**

3.2.7 Counsellor’s role in facilitating the resolution of other issues

In ten cases the counsellor explored other areas of the client’s life. The one client said, **“She took me to places that I’ve never thought about.”** another said, **“She wanted to know about my family life, work and things.”** Eight respondents who raised other issues themselves reported that they did so because they felt comfortable with the counsellor **“I felt so comfortable with her that I could speak to her, you know because I needed to speak to someone and she was there.”**

3.2.8 The impact of other support systems

Seventeen respondents had emotional support beyond the counselling and they all said that this aided their recovery. They derived emotional support from various sources including family, friends, their church and employers **“I did get help from my church and from the school. My husband was holding me so tight.”**

Two of three people who did not have support felt that they were at a disadvantage but the third one said, **“You know I don’t underestimate (I think he actually means overestimate) other people. You don’t know what advice they give you because you know some people say this and that and then when you do that you see that it doesn’t work out.”**

3.2.9 The outcome of counselling

3.2.9.1 The need to help others

Two of the respondents reported that since the incident they have felt the need to volunteer at organizations which deal with traumatised people. The rest of the sample felt that they would offer support to people whom they know and that they would refer them for counselling because they feel that professionals need to do the counselling. **“It (volunteering) is not a burning desire but if it is somebody close to me I will help.”** Another respondent said, **“I am willing to help people but not to do the counselling.”**

3.2.10 Growth achieved as a result of counselling

Two respondents who did not discuss other issues besides the trauma reported that they did not feel that they had changed in any significant way. For them the counselling was successful because their symptoms were resolved. **“I changed because I feel better, I forgot I put something here and I was looking. It was bad but now it’s better.”** The respondent meant that she had experienced memory problems after the event and that this condition improved as a result of the counselling.

Two of the respondents who had discussed other issues also reported they did not change in their self-awareness but that they had changed in that they are more cautious and aware of safety, **“It has changed me to be more alert, and it has made me more aware.”** Both of these clients attended only two counselling sessions. The sixteen respondents who reported change in their self-awareness identified more than one area of growth.

Respondents identified the following areas of growth:

Table no. 3.7- Areas of growth achieved

Areas of growth achieved	Number of respondents
Greater connection with others	8
Changed their priorities in terms of what they view as important e.g. from working all the time to realising how important their family is.	5

Areas of growth achieved	Number of respondents
Self- discovery in terms of self-awareness	4
Assertive about meeting their own needs	3
Less afraid of change	2
Calmer and at ease	2
Realised that life is valuable because death can occur at any time	1

Quotes illustrating the post-traumatic growth achieved by respondents

- 1) "I spend more time with my daughter, my mother and family. I listen more."
- 2) "I feel like I belong here, I have a right to be here. I started implementing 'I' and it's working, it's working a lot."
- 3) "I was caught in a comfort zone. She told me no you want more, if you want more, there is more. Just apply and that's what I did. Even though I get letters saying 'we regret to inform you', but the mere fact that I just did it (applied for jobs)."
- 4) "It was a life changing thing for me. I was almost dead. So I could either go home in one part or stay on that path and the choice wasn't to stay there and with the counsellor, it made me realise what was the proper way for my life."
- 5) "I had to find myself."
- 6) "I have become a lot calmer, more peaceful. Less moody, less angry with the people closest to me."
- 7) "Life can be taken away from you in a flash...(you can die)."
- 8) "I used to be very fussy and tidy. I used to nag everybody. I have realised that these aren't the important things in life, so I've got a new outlook on life."
- 9) "I used to hide if certain people came to the house that I didn't want to see, now I know, be straightforward in a nice manner."
- 10) "I am just a lot more introspective I guess about the decisions that I make and I ask myself more questions".

3.2.11 Recommendations about services at the Centre

All of the respondents would recommend the Centre to others in need of counselling. One respondent said, **“I would recommend the Centre because in this day we realise that trauma counselling is not a luxury.”** Another said that **“I would recommend the Centre because it helped me to deal with my feelings and I think someone who is going through the same thing should go for counselling.”**

They generally found the service to be excellent and only three of them made specific recommendations which included: 1) that the service needs to be marketed so that more people know of the Centre’s existence, **“more people should know about its existence because I didn’t know about it all.”** 2) the Centre needs to be less formal and counselling rooms need to be more child and adolescent friendly, **“they’ve got nice offices but they need to put something more for children or teenagers like flowers or their style of furniture.”**

3) Staff need to give clear directions as to where the Centre is because clients find it distressing when they get lost in an unfamiliar area especially those people who were hijacked, **“A lot of people will get lost if you don’t tell them how to get here. To get to Chapel Road is horrific.”** The respondent meant that it is not easy to find the Centre and that this is distressing to people who have experienced trauma, because they are so insecure about a lack of safety.

3.2.12 General comments about the research interview

All of the respondents stated that they were not distressed by the research interview. One respondent remarked that the research was valuable as it indicated that The Trauma Centre wants to evaluate the service because of clients being important to the Centre. He said, **“I feel that this is beautiful. To me this is enlightenment, that there are people out there interested that want to improve...”** Another respondent said, **“It did bring back some memories but I can deal with it so it’s fine.”**

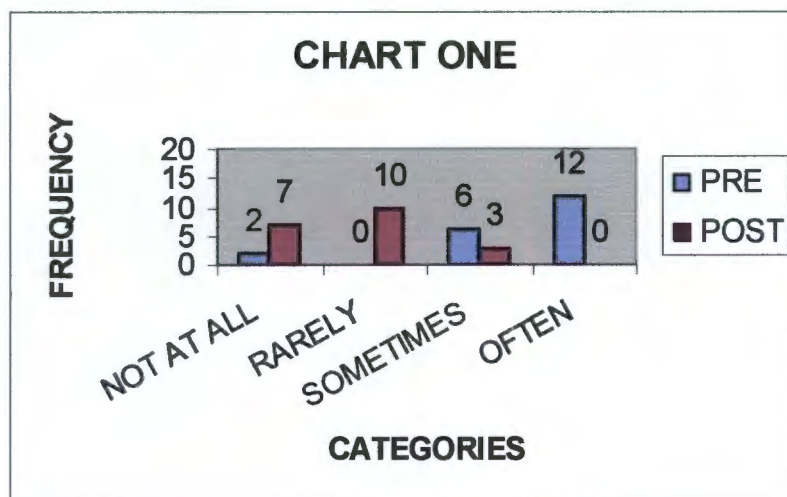
All of the respondents also indicated that they would like feedback about the results of the study. They agreed that this could be in the form of a letter. A copy of this letter is included as appendix III

3.3 Presentation of quantitative results

As discussed in Chapter one, two scales were administered to the subjects. The scales consisted of the same categories but the first one asked the participants to identify how they felt when they first presented to the Centre. The second scale elicited how they felt when they terminated counselling. The respondents completed both scales in my presence.

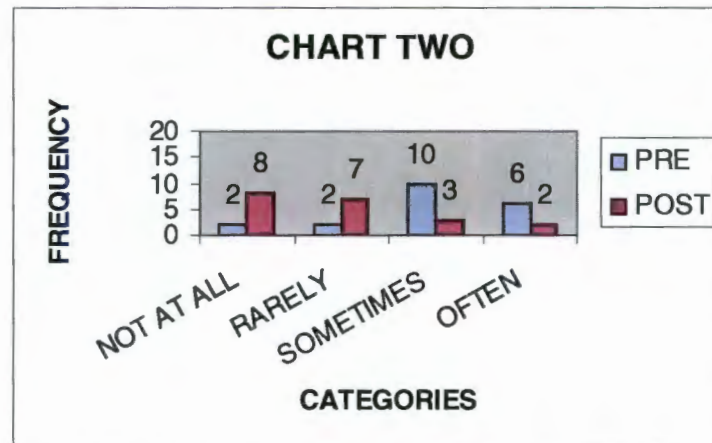
I administered the first scale at the beginning of the research interview and the second completion of the scale just before the end of the interview. Respondents therefore had to reconstruct their symptoms pre and post counselling. I will present the responses to each category by illustrating the difference between the first and second responses of the sample.

3.3.3.1. Item one- "I thought about it when I didn't mean to



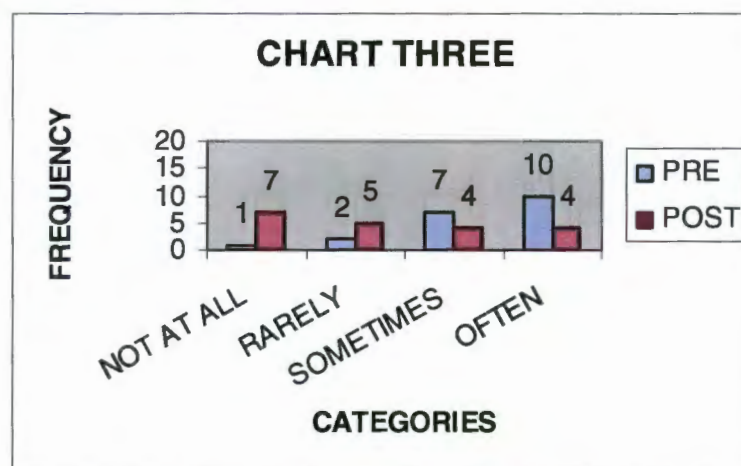
It is evident that subjects reported a marked improvement in this category, especially if one sees that sixty percent of the subjects chose the 'often' category before counselling and no one selected this category post counselling.

3.3.2 Item two- “I avoided letting myself get upset when I thought about it or was reminded of it”



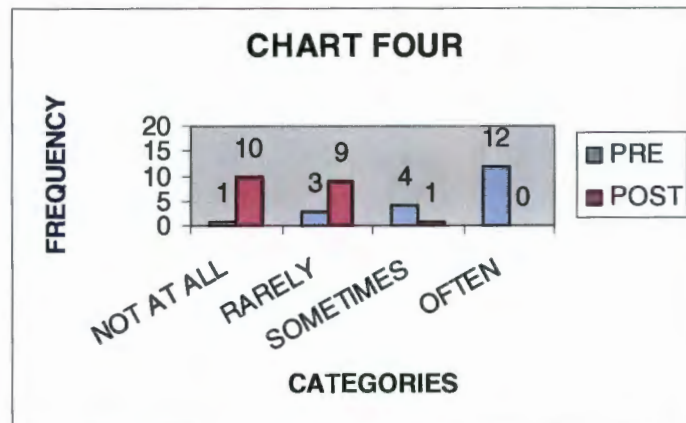
This item did not elicit such intense reactions as the first item with only six people choosing the ‘often’ category prior to counselling. However, there were still two people who selected this option after treatment. It is important to remember that the avoidance aspect of the item is the issue because avoidance is so common after trauma.

3.3.3 Item three- “I tried to remove it from my memory”



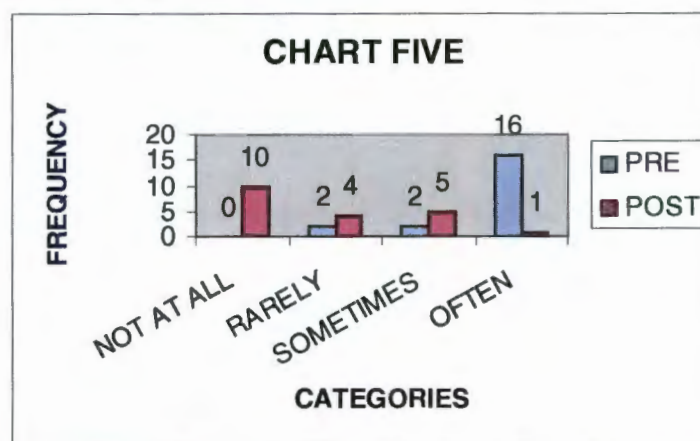
From the above chart it is clear that the majority of respondents wanted to forget about the event with fifty percent of the respondents selecting the ‘often’ category prior to counselling and over a third selecting the ‘sometimes’ category. There was an improvement of approximately fifty percent in both categories after counselling.

3.3.4 Item four- “I had trouble falling asleep or staying asleep because pictures or thoughts of it came into my mind”



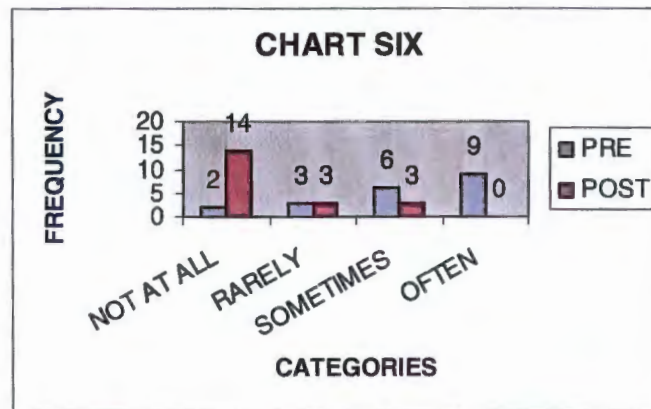
Insomnia significantly affected sixty percent of the sample before counselling. Fifty percent of the sample completely recovered with regard to this symptom and no one selected the ‘often’ category post counselling.

3.3.5 Item five- “I had waves of strong feelings about it”



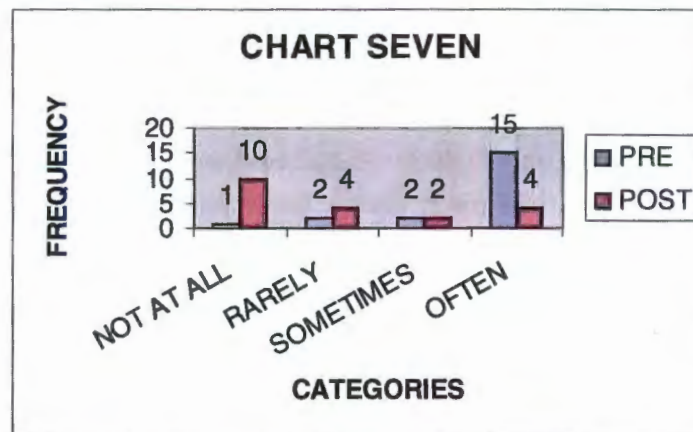
This statement elicited the most intense reaction as compared to the other statements, with eighty percent of the sample selecting the ‘often’ category prior to counselling. This is not surprising if one looks at the range of intense emotions described by the participants in the qualitative responses at the beginning of chapter three. There was also a marked improvement in that fifty percent of the sample selected the ‘not at all’ category post counselling.

3.3.6 Item six- "I had dreams about it"



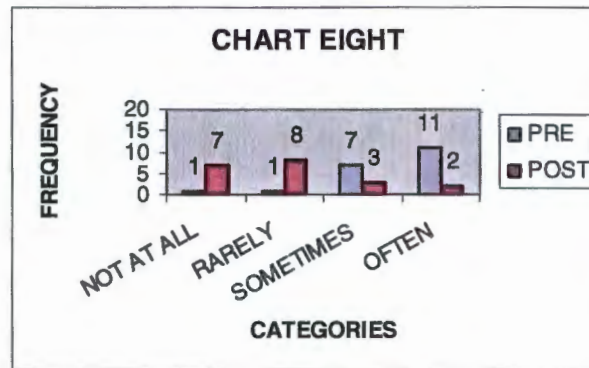
Just below fifty percent of the sample selected the 'often' category prior to counselling and no one selected this category after counselling. Two respondents selected the 'not at all' category prior to counselling but the recovery rate for this symptom appears to be good with sixty percent of the sample selecting this category post counselling.

3.3.7 Item seven- "I stayed away from reminders of it"



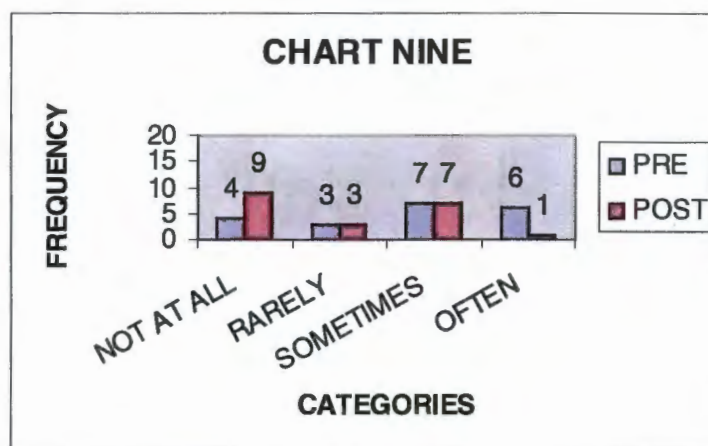
Avoidance of stimuli associated with the event appeared to have been significant with seventy five percent of the sample selecting the 'often' category pre counselling. Along with the third statement, **"I tried to remove it from my memory."** this statement had the highest number of respondents (twenty percent) selecting the 'often' category post counselling. One can see how these items would relate in the results because they have similar meanings.

3.3.8 Item eight- "I felt as if it hadn't happened or it wasn't real"



Fifty-five percent of the sample selected the 'often' category prior to counselling thus indicating depersonalisation and this decreased to ten percent post counselling. There was also a significant decrease in the 'sometimes' category with a decrease of more than fifty percent pre and post counselling.

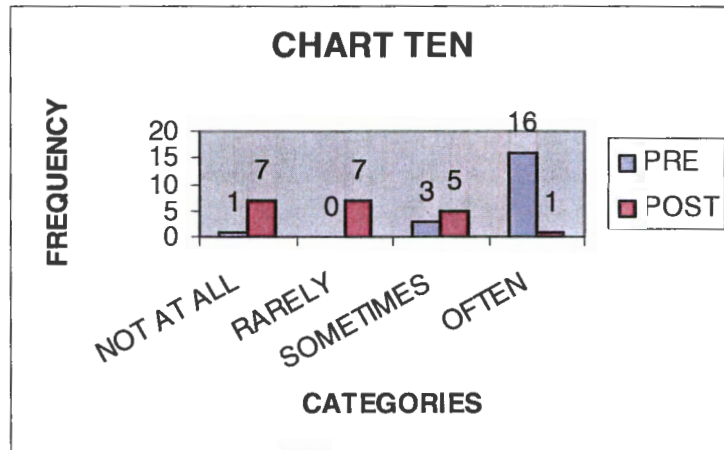
3.3.9 Item nine- "I tried not to talk about it"



The most significant aspect of this symptom it would seem as if the numbers remained the same in the 'rarely' and 'sometimes' category pre and post counselling.

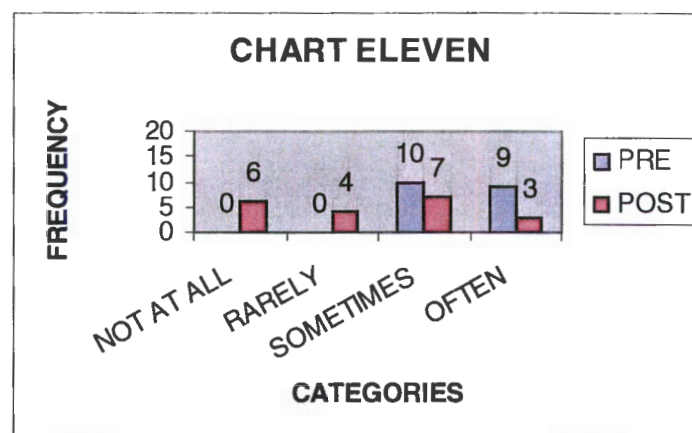
However on closer analysis only two respondents selected the same options pre and post counselling.

3.3.10 Item ten- “Pictures of it popped into my mind”



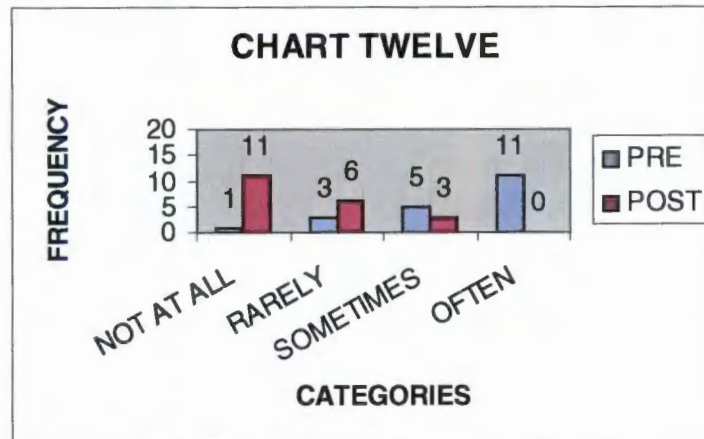
Along with item five, this item had the highest number of respondents selecting the ‘often’ category prior to counselling. Although twenty five percent of the sample still selected the ‘sometimes’ category after counselling, only one person selected the ‘often’ category.

3.3.11 Item eleven-“Other things kept making me think about it”



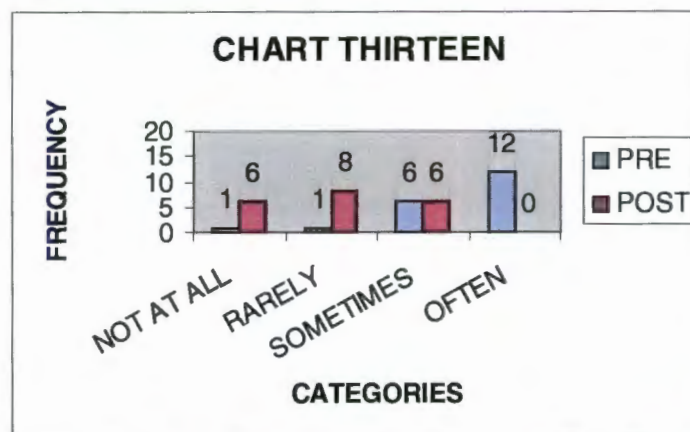
Seventy-five percent of the respondents avoided reminders of the event; however, only forty five percent of the subjects selected the ‘often’ category before counselling in this item. This could be because they avoided reminders of the event in the first place.

3.3.12 Item twelve-“I was aware that I still had lots of feelings about it, but I didn’t deal with it”



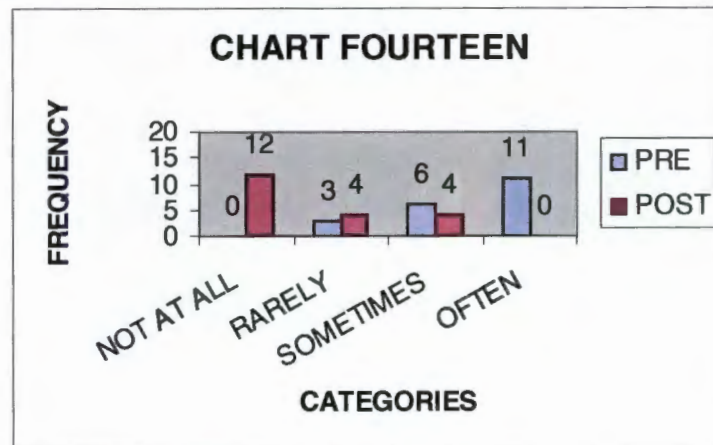
What is interesting to note about this item is that eleven respondents selected the ‘often’ category pre counselling and the same number selected the ‘not at all’ category post counselling. Eight of the eleven respondents who selected the ‘not at all’ category post counselling had selected the ‘often’ category prior to counselling.

3.3.13 Item thirteen-“Any reminders of it brought back feelings of it”



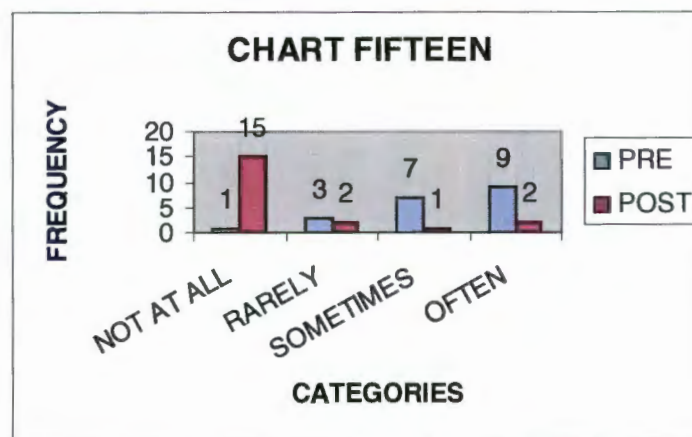
This item is very similar to item number thirteen and it is interesting to note the inconsistency in that sixty percent of the respondents selected the ‘often’ category before counselling compared to forty-five percent in item eleven. This could be due to the use of the word ‘feelings’ in this item or perhaps the respondents did not fully understand the question.

3.3.14 Item fourteen-"I tried not to think of it"



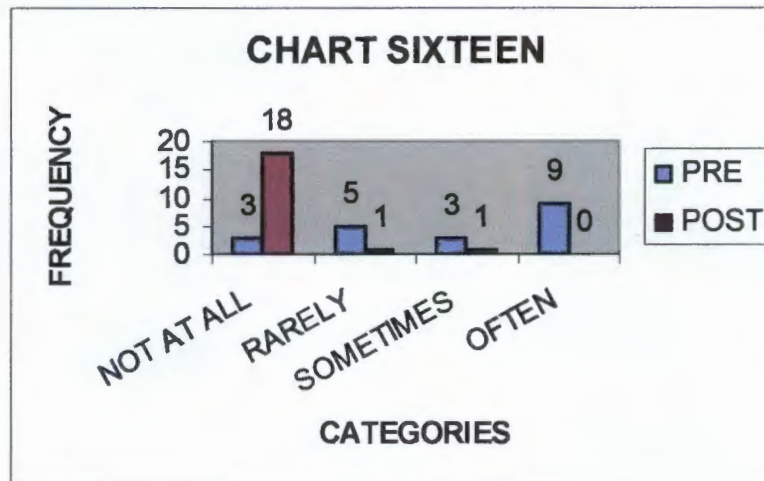
This item is very similar to the third item and the responses to this item are consistent with the responses to the third item.

3.3.15 Item fifteen-"My feelings about it were kind of numb"



This item had the second highest selection of the 'not at all' category post counselling with seventy five percent of the respondents selecting this option. This is to be anticipated because one would expect that the respondents dealt with their emotions in counselling. This implies that they would be aware of their emotions and therefore not experiencing depersonalisation.

3.3.3.16 Item sixteen-“It affected me physically e.g. headaches, cramps etc.”



Ninety percent of the subjects selected the 'not at all' category after counselling. Three respondents had selected this option pre counselling which means that seventy- five percent of the sample recovered completely with regard to somatic complaints. No one selected the 'often' category post counselling.

3.4 Key findings

A detailed discussion will be included in chapter four. The most significant finding is that none of the respondents had negative counselling experiences nor did any of them recommend any changes for the counselling service of the Centre. All the respondents had a reduction in their symptoms and felt that they had recovered from the trauma. The majority reported that they had discussed issues besides the trauma in their counselling and that they had experienced some growth in self-awareness.

Conclusion

In conclusion this chapter firstly presented tables illustrating the demographic details of the sample, the nature of the traumatic events experienced by the participants and the sources of referral to the Centre.

Both the qualitative and quantitative results of this research were also presented.

The qualitative results were discussed by means of different categories and quotes from the interviews were included to illustrate these themes.

The quantitative results were presented by means of graphs. This chapter also briefly highlighted the key findings of the study. The results will be discussed in depth in the next chapter which will also include conclusions and recommendations for the Centre.

Chapter four

Discussion of results, conclusions and recommendations

The concluding chapter of this dissertation includes a discussion of the results of the research, which were presented in chapter three, my conclusions and recommendations for The Trauma Centre for counselling procedures or policies as well as future research. I will link the discussion of the results with the relevant literature as discussed in chapter two. The discussion will be presented under the headings of my aims and objectives.

4.1 Discussion of the results

The results of the research will now be discussed under the following headings, which are based on the research questions and aims of the research which were discussed in chapter one. It is necessary to restate the research questions and aims for the sake of clarity. The two main research questions were:

- a) How have clients experienced the counselling they received?**
- b) How do clients feel counselling helped them to achieve growth in self-awareness?**

These questions encompassed sub questions of how clients experienced the new appointment system, the past and present symptoms of clients, whether there had been a subjective improvement in their condition, their sense of growth in self-awareness and their opinions of the general services at the Centre in the management of trauma.

The research aims were to describe clients' subjective experience of the counselling process in the management of trauma and to determine clients' opinions on how counselling assisted them to achieve post-traumatic growth in the form of greater self-awareness.

There were a number of objectives:

- a. To determine what symptoms clients had on presentation to the service.
- b. To determine their current symptoms.
- c. To determine what recommendations clients have for the Centre regarding the counselling.

- d. To determine whether the new appointment system is useful or not in helping to decrease clients' anxiety about coming for counselling.
- e. To determine whether clients would recommend the Centre to others.
- f. To determine what the reasons for the termination of treatment were.
- g. To determine whether clients dealt with other issues besides the traumatic event in counselling.
- h. To examine the relationship between the client and the counsellor.
- i. To determine whether clients had other support besides the counselling.

I will now discuss the results of the study and the first research question was how the clients experienced their counselling.

4.1.1 Research question 1- A description of clients' subjective experience of the counselling process

The most important finding was that all the respondents had positive counselling experiences at The Trauma Centre and they attributed this to a number of factors. I have discussed my concern about respondents feeling unable to provide me with negative feedback in chapter one; however, if one also refers to Plummer (2001) he argues that in deciding whether people are telling the truth one needs to look at their sincerity and authenticity. I am confident that the respondents were being sincere and authentic when they gave feedback about the counselling service at the Centre based on the coherence of their verbal expression and my observation of their non-verbal and paraverbal behaviour during the research interviews.

I will discuss this section under different headings and the first area I wish to discuss is the outcomes of the counselling process:

4.1.1.1 Outcomes of counselling

The definition of counselling states that counselling "is the skilled and principled use of relationships which 1) develop self knowledge, 2) emotional acceptance and growth, and 3) personal resources" (Rowland et al, 2000: 223).

If one examines this definition one can gain an idea of what the respondents found helpful about counselling. The outcomes of counselling will be discussed under the following headings:

a) The development of self- knowledge

Sixteen of the respondents reported that they experienced growth in self knowledge as a result of counselling. One of my research questions was whether counselling assisted the respondents with achieving an increase in self knowledge and I will discuss this in more detail later in this chapter.

b) The development of emotional acceptance and growth

The results of the study indicate that clients found the following aspects of counselling to be beneficial: 1) feeling supported and being listened to and 2) having someone to talk to. This constitutes emotional acceptance by the counsellor. The respondents' achievement of emotional acceptance is what is important in this instance.

Eight of the respondents reported that they felt a greater connection with other people after their counselling. I think that the fact that all of the respondents also could share their stories without becoming distressed and their empathy for other survivors of trauma indicate that they achieved emotional acceptance and growth. The indications are that all of the respondents have returned to their pre trauma functioning e.g. they have all returned to work further indicates their achievement of this area.

c) The development of personal resources

More than a third of the respondents perceived as positive their being educated about the symptoms they were experiencing and being assisted with recovery through advice on coping mechanisms. This increased their personal resources. This knowledge assisted them with coping with their distress and resolving the trauma.

d) Resolution of symptoms

This is another area that will be discussed in more detail below; however, one needs to recognise that for the respondents the resolution of symptoms was a vital outcome of counselling. They all found their symptoms very distressing and the fact that their symptoms were resolved was an important in their perceiving the counselling as having been positive.

4.1.1.2 The counsellor being perceived as an expert in trauma management

The counsellor being perceived as an expert in trauma management was also very important to the respondents. This is confirmed by the literature as being an important factor in treatment (Keijsers 2000, Williams 2002). This study supports this view because the results indicate that because the respondents perceived their counsellor as skilled in trauma management, they were confident that the counsellor would be able to treat them effectively. The perception of the counsellor as an expert in trauma management was based on a number of factors:

a) Working at a specialist agency

The Trauma Centre specialises in trauma counselling and provides services to only those people who have been involved in the types of incidents that the respondents were involved in. The respondents therefore believed that the counsellor was experienced in this field because counsellors at the Centre work with this type of trauma on a daily basis.

b) Locating the trauma in the context of other traumas

In sixteen of the twenty cases, respondents resolved previously experienced traumas during counselling at the Centre. The fact that counsellors were able to locate the current trauma in the context of other traumas was a vital part of the respondents' recovery and led to personal growth in the form of greater self-awareness.

Counsellors at the Centre are aware as a result of their training and experience that current traumatic events often evoke unresolved previous traumas. They are therefore aware of the necessity of eliciting and dealing with the underlying traumas as well as the current traumatic event.

c) Debriefing skills

Based on my observations during the research interviews I think that all of the respondents benefited from their initial debriefing. Three of the respondents actually highlighted the value of debriefing because they felt that they needed to work through the event in a detailed manner in order to make sense of it.

Debriefing or “crisis counselling” as it is referred to at the Trauma Centre consists of the counsellor asking the clients about what happened in as much detail as possible, their thoughts and feelings during the event and their current thoughts and feelings. The counsellor also explores whether the client had any similar previous experiences and how they dealt with these experiences in order to access previous coping mechanisms. An important aspect of the debriefing is the process of psycho-education.

Crisis counselling is done in a flexible manner and clients dictate the process in that the counsellor will work at a pace which is comfortable for the client. The counsellor will also explore issues which appear to be significant for the client.

The emphasis is therefore on dealing with what is relevant for the client and not on following all the steps in the debriefing process. Crisis counselling can therefore take place over several sessions.

In chapter two I presented the debate around the efficacy of crisis counselling and a number of authors were cited opposing the use of crisis counselling (Raphael & Lenore 1995, The Cochrane review of 1997 which encompassed eleven studies, Burns 2002, Litz et al 2002 and Ormerod 2002). I also cited a number of studies which support the use of crisis counselling (Kos et al 1993, Bass and Davis 1994, Hajiyanis & Roberts 1999, Stacey 1999, Crossley 2000, Rynearson 2001).

Based on this research crisis counselling as it is conducted at the Trauma Centre is beneficial to the clients. I think one must not underestimate the power of being able to share a very distressing story with someone who is able to deal with the traumatic material and assist with advice on how to cope with the event, based on the evidence of recovery in this study.

The following statement by Hannah Arendt in Plummer (2001:253) captures my opinion on the value of debriefing. She said, “All sorrows can be borne if you put them in a story or tell a story about them.”

d) Psycho-education

The literature emphasises psycho-education, which is where the counsellor educates the client about their symptoms, as an important aspect of treatment (Herman 1992, Scignar 1996, Hajiannis & Robertson, 1999). The value of psycho-education lies in the fact that it reassures the clients that their symptoms are expected and that they are not insane (Hajiannis & Robertson, 1999).

In this study more than a third of the respondents emphasised the importance of being educated about the human reactions to trauma and how reassuring this was to them because the majority thought that they were becoming psychotic. They then understood that their reactions to the trauma were normal and were able to take charge of their reactions.

The literature also emphasises that the counsellor needs to focus on coping strategies rather than on pathology (Herman 1992, Scignar 1996) and in this study a quarter of the respondents highlighted this factor as an important aspect of their positive experience of counselling.

e) Creation of a safe environment

Safety was another important factor for the respondents and this included physical and emotional safety. The literature confirms that the experiencing of a traumatic event is overwhelming for most individuals (Burgess and Lazarre 1976, Herman 1992, Scignar 1996, Williams et al 1999). Burgess and Lazarre (1976:192) confirm this with their statement that “few categories of human behaviour provoke more gut level of responses than that of trauma.”

The importance of safety was evident in responses to a number of questions on the questionnaire as well the respondents’ subjective accounts of their experiences.

Fifteen of the twenty respondents spontaneously reported that they felt fear during and after the incident and they all thought that they were going to die. The emotional safety of the counselling consisted of a number of aspects and these included: *1) the fact that the counselling was confidential, 2) the counsellor was able to listen to the traumatic material without becoming distressed, 3) The counsellor was able to contain the respondents' distress and 4) The Trauma Centre is secure in that it has a security officer on duty and access is restricted through a security gate.*

4.1.1.3 Negative counselling experiences elsewhere

None of the respondents had a negative counselling experience at the Centre. Three of the respondents had negative experiences at other organizations and they used these experiences to demonstrate why they found the counselling at the Centre beneficial.

It appears as if the counsellors at other organizations did the opposite of what the respondents found to be helpful at the Centre. This included:

- a) One respondent did not make an appointment at the other organization when she heard what this counsellor's fees were.
- b) The counsellor showed a lack of concern or interest in them.
- c) They received no assistance in terms of support or guidance.
- d) The counsellor was perceived as inexperienced in trauma management.
- e) The physical environment at the other organization was not conducive to counselling, for example a lack of privacy.

4.1.1.4 The Trauma Centre's environment

A number of respondents also highlighted the physical environment of the Centre as having contributed to their positive counselling experience. I must say that I did not expect this issue to emerge as strongly as it did because I assumed that the respondents would have been preoccupied with their emotions and would therefore not have noticed the environment of the Centre. Instead the respondents welcomed the calm atmosphere and the secure nature of the Centre.

The respondents also acknowledged the friendliness of the receptionist and security officer and this has implications for the Centre in terms of the importance of frontline staff. It is also interesting that for the respondents, the fact that they did not have to pay fees was an important factor in ensuring a positive counselling experience. The Centre currently offers a free service however is debating at present whether it should introduce a fee system which will generate an income for the organization.

4.1.2 Objective 1- The symptoms clients had on presentation to the service

Firstly if one examines the definition of trauma it is evident that in this study the event “attacked the psyche” and broke “through the defence system” and “significantly disrupted” all the respondents’ lives (Mitchell & Everly 1997: 7).

The respondents all had similar symptoms, which the literature outlines, as common after a traumatic event (Scrignar, 1996: 19). This included insomnia, flashbacks of the event, illusions, hallucinations and feeling as if the traumatic event is recurring. The internal or external cues lead to intense psychological or physiological distress e.g. cramps or headaches (Scrignar, 1996: 19). Most of the respondents selected the ‘often’ category for items on the pre counselling questionnaire.

A number of the respondents reported that they suffered from depression and anxiety. Scrignar (1996) states that the traumatised person often presents with symptoms of depression. Scrignar (1996) further states that victims are often overly aware of what is happening around them, and this was very evident in this study with seventy-five percent of the respondents attesting to being hypervigilant.

The fact that respondents experienced a range of intense emotions emerged in both the qualitative and quantitative data. They all experienced intense levels of fear after the incident which is appropriate bearing in mind that all of the incidents were unexpected and the very nature of trauma implies that it evokes fear. What is quite startling is that weapons were used in fifteen of the twenty cases and that guns were involved in fourteen of these cases. “Startling,” because this indicates how prevalent the use of firearms in South African society is.

The item which tested the presence of intense emotions had the highest pre counselling selection of the 'often' category as compared to the other items. Eighty percent of the sample selected 'often' in this category. Along with this item, flashbacks appeared to be the most common symptom amongst the respondents. Linked to this was the high level of avoidance of stimuli associated with the event (seventy-five percent of the respondents avoided reminders of the event). Avoidance of any stimuli associated with the event is one of the criteria for the diagnosis of ASD or PTSD (Scrignar, 1996).

There appeared to be some inconsistencies with two items which received different scores. Both items examined if the presence of stimuli associated with the event would bring back memories of the event. In the one item sixty percent of the respondents selected the 'often' category before counselling compared to forty-five percent in the former item. This could be due to the use of the word 'feelings' in the latter item, or perhaps the respondents did not fully understand the question.

4.1.3 Objective 2- The clients' current symptoms

Harvey (1998) suggests that one needs to look at whether symptoms have been mastered when one examines the issue of recovery. The longest time between the event and the research interview was nine months and the longest period between the termination of counselling and the research interview was six months.

The results indicate that all of the respondents' symptoms improved and this is evident in the decrease in the selection of the 'often' and 'sometimes' categories in all the items in the post counselling questionnaire. The improvement of symptoms is also based on the subjective accounts of the respondents i.e. they all said that their symptoms had improved.

The most significant recovery was with regard to the somatic complaints which clients had with ninety percent of the sample selecting the 'not at all' category post counselling. The respondents who felt that they were somehow responsible for what had happened to them, all reported that at the end of counselling they realised that they were not responsible in any way. Furthermore, three respondents who were commenced on anti-depressant medication after the event no longer require the medication.

The literature also states that counselling is considered successful when clients return to their pretraumatic functioning (Scrignar, 1996) and all of the respondents reported that they have returned to their premorbid levels of functioning and that they were no longer avoiding any stimuli associated with the event. As mentioned above seventy-five percent of the respondents said that they often avoided reminders of the event pre counselling whereas only twenty percent selected the 'often' category post counselling. Fifty percent of the sample selected the 'not at all' category in this item post counselling.

There was also a significant decrease in respect of the presence of flashbacks with eighty percent of the respondents selecting the 'often' category prior to counselling compared to five percent post counselling.

It can therefore be said that the counselling at the Centre assisted the respondents with symptom alleviation as well as resolution of the intense emotions that they had at the time. This also indicated by the fact that despite having to talk about the event during the research interview, none of the respondents found the research interview to be distressing. Based on my observations during the research interviews, it is evident to me that the respondents did not relive their traumatic experiences. Instead they only described them to me. This also demonstrates that their counselling assisted them with recovery.

4.1.4 Objective 3- The resolution of other issues in counselling

Wright (1991: 23) states "the Chinese interpretation of the word crisis describes it as an opportunity for change and personal development". This was certainly true in this study where ninety percent of the respondents used their counselling to discuss issues besides the trauma as well.

The results also indicate that half of the respondents who dealt with other issues were unaware of these issues when they commenced counselling. According to Solomons (1988), trauma can evoke underlying conflicts. The respondents, who dealt with other issues, felt that this was a very beneficial aspect of their counselling.

A number of different issues were discussed. This included: family issues, unresolved childhood issues, previous losses, employment concerns and other difficulties, for example substance abuse.

The results of this study suggest that the respondents who resolved underlying conflicts were the ones who experienced growth in self-awareness. It is also interesting to note that the two respondents who did not discuss other issues felt that their counselling was successful because their symptoms had been resolved and they ceased counselling of their own volition.

This indicates that clients can benefit from only two sessions because these respondents also said that they felt that their situation had changed since they attended counselling.

The indications are that clients do need to have ongoing sessions to achieve growth in self-awareness. Another research question which I had was what clients' opinions were on how counselling assisted them with achieving greater self-awareness.

4.1.5 Research question 2- Clients' opinions on how counselling assisted them with achieving post-traumatic growth in the form of greater self-awareness.

The literature suggests that with the successful treatment of trauma, victims can experience growth in other areas of their lives as well as recovering from the trauma (Wright1991, Hybels-Steer 1995, Matsakis 1998, Lifton and Olson in Horowitz 1999). The results of this study concur with this view with eighty percent of the respondents indicating that they had experienced growth in terms of self-awareness.

There were a number of areas of growth described by the respondents with the most common areas being a greater connection with others and respondents experiencing a change in their priorities. In terms of connection with others, the growth occurred mostly within the family relationships of the respondents. Other changes included: the respondents being more assertive about their needs, less afraid of change, realising the value of life and discovering more self-awareness.

Another area of growth for survivors is that they develop empathy for people who have also suffered (Matsakis, 1998) and this was very evident in this study where ninety percent of the sample reported that they would offer support to other victims of trauma and would inform them about counselling. A number of authors discuss the various ways in which survivors of trauma can achieve growth in self-awareness (Wright 1991, Everstine & Everstine 1993, Hybels-Steer 1995 and Matsakis 1998). A review of the work of these authors confirms that the findings of this study are indicative of the common ways in which survivors of trauma experience growth after the event.

4.1.6 Objective 4- Clients' recommendations for the counselling and the Centre

Only three of the respondents had recommendations for the Centre and these recommendations did not target the counselling service. Instead they focused on logistical issues such as making the counselling environment more child-friendly, marketing the service more and ensuring that proper directions to the address are given. All the respondents indicated that they thought that the counselling service should remain as is because it met their needs fully.

4.1.7 Objective 5- Clients' perceptions of the new appointment system

The appointment system is perceived as a very effective system with nineteen of the twenty respondents having supported the use of such a system. It would appear from the results that the appointment system is useful for a number of reasons with the most common reason being that having to wait to be seen indefinitely would have raised the anxiety of the person. In light of the fact that victims of trauma experience high levels of distress (Scrignar 1996, Mitchell & Everly 1997) this is clearly a very important issue for the Centre to be aware of.

4.1.8 Objective 6- Would clients recommend the Centre to others

All the respondents indicated that they would recommend the Centre to any person who required trauma counselling because of their positive counselling experience. This is important because, as the literature states, the issue of service quality has become an international issue in that if clients are satisfied with the service, they will continue to use the service (Patel 1998, Van Niekerk 1998) and being able to demonstrate client satisfaction will assist organizations with obtaining funding.

Van Niekerk (1998) states if the service of an organization is of high quality, clients will continue to make use of the service. The Trauma Centre can be aware that clients can therefore be a valuable referral source in that they can tell other people about the service.

4.1.9 Objective 7-The duration of treatment and the reasons for termination

The results of this study confirm that trauma counselling can be effective within a short-term model with the average number of sessions attended by the respondents being 4.7 sessions. This is confirmed by the literature where all the treatment models appear to advocate that trauma counselling is best done through a brief model of intervention (Ryan 1994, Scott & Stradling 1994, Hajiannis & Robertson 1999).

Scott & Stradling (1994) cite a large number of studies that have found that 50% of clients are better after eight sessions and that clients don't really benefit after more than 26 sessions. The highest number of sessions in this study, attended by a respondent was fifteen. With regards to termination, the majority of the respondents decided to terminate counselling because they felt that their condition had improved, and this in itself suggests that they felt that they had recovered from the event.

4.1.10 Objective 8- The relationship between the client and the counsellor

The literature review confirms that the counselling relationship is an integral part of treatment and largely determines whether treatment will be successful (Howe 1993, Mitchell 1993, Saunders 1999, Keijsers 2000, Torgalsboen 2001, Williams 2002). A number of studies have rated the counsellor's human qualities as the most important factor in treatment (Saunders 1999, Keijsers 2000, Torgalsboen 2001, Williams 2002).

In terms of the research interview, I am mindful of the fact that I relied on the respondent's verbal ability and that some of the respondents may have had difficulty in verbally conceptualising the counselling relationship. During the interview, however, I did not observe this to be the case. I observed that all of the respondents were able to spontaneously verbalise what they found positive about the counselling relationship.

Furthermore the respondents who spoke Xhosa or Zulu sometimes struggled to find the exact words to describe aspects of the relationship but they were eventually able to explain what they meant to say.

The findings of this study concur with the literature with all of the respondents highlighting the counsellor's human qualities as the most helpful to them. These qualities include warmth, caring, acceptance and understanding.

The literature also emphasises that gender issues and racial and religious differences between the counsellor and the client impact on the counselling relationship. (Banks 1995, Hoff 1995, Schmidt 1996 and Gehart & Lyle 2001). The results of this study confirm that gender does indeed play a role in the counselling relationship with more than half of the sample reporting that the gender of their counsellor impacted on their experience of counselling in that they felt more comfortable with a female counsellor than they would have with a male counsellor. In addition to this three of the respondents preferred a female because their assailants were male and they felt it would be difficult to relate to a male counsellor.

Respondents could have felt that they had to be politically correct and say this was not a factor but my impressions during the interview was that respondents were being sincere in their reports. I observed that the respondents were very comfortable in the research interview and that they expressed opinions freely and without hesitation. They spoke thoughtfully. The one respondent felt that it would have been difficult for her if her counsellor was of the same cultural group as her assailants because she would have felt unable to express her anger at them.

On the other hand, one of the respondents saw a counsellor who was of the same cultural group as her assailants but she felt that this was not a hindrance because her counsellor was a professional and that her anger did not extend to the entire religious group.

4.1.11 Objective 9- The importance of other support

From this study it is also evident that emotional support from family, friends and other support systems assists with the recovery of the client. In both international and South African models of treatment, clients are encouraged to mobilise their support systems (Scrignar 1996, Hajiyannis & Robertson, 1999). The majority of the respondents received emotional support from people besides their counsellor with only three respondents reporting an absence of other support. Two of the three felt that this retarded their recovery. This has implications for the Centre in that involving the family/ significant others in treatment need to be strongly considered.

4.2 Conclusions

The following conclusions can be made based on the results of this research:

a) Counselling can be a positive experience

It is evident from the results that all of the respondents had a positive counselling experience and that the treatment of trauma paradoxically does not have to be a negative experience but can be an experience which leads to growth in self-awareness. I have discussed the factors which I believe contributed to the respondents experiencing their counselling as positive in the discussion of the results.

b) Trauma can be life-changing

Everstine and Everstine (1993) say that trauma survivors see life differently because they have been forced to confront their own mortality. This can explain why so many of the respondents reported that they have grown in terms of self-awareness if one looks at how many of the respondents in this study thought that they were going to die during the event. The results also indicate that the majority of the respondents reported that they have achieved growth in terms of self-awareness.

c) The trauma must be located in the context of other traumas

Based on the results of this study, I believe that counsellors must be alert to raising and resolving other emotional traumas in their lives.

Cabrera (2003) describes this process very aptly when she says that the counsellor must obtain the client's 'inventory of wounds' and that the counsellor must then assist the client with resolving these wounds so that the client can completely heal.

d) The impact of religion, race and gender

Gender appeared to have an impact on the counselling process. It should be noted that all of the respondents had female counsellors. This is consistent with the Centre's population because the majority of counsellors at the Centre are female. More than half of the sample reported that the gender of their counsellor impacted on their experience of counselling and that they preferred female counsellors. Contrary to the literature religion and race did not seem to be significant factors in treatment with only ten percent of the sample having felt that religion and race were significant in their counselling.

e) Fees

For some respondents it was an advantage that they did not have to pay because they could not afford to pay for counselling.

f) Holistic service

The results indicate that many of the respondents had somatic complaints. I therefore think that the fact that the Centre offers a holistic service involving counselling along with aromatherapy which treats the somatic complaints is important.

g) The need for safety

Trauma can be seen as taking away the person's sense of safety in the world and clients have a great need for safety and security.

4.3 Recommendations

I will be discussing the recommendations for The Trauma Centre under three headings i.e. recommendations for practice, recommendations for training and recommendations for research.

4.3.1 Practice

a) The need for safety

Safety is an issue which counsellors need to be cognisant of at all times because it was important for the respondents to feel physically and emotionally safe. Counsellors therefore have to create a safe and containing environment for their clients and the Centre must ensure that the organization is a safe place to be.

b) The recruitment of staff

Based on the fact that respondents felt that the counselling relationship was a vital aspect of their recovery I would recommend that the Centre consider the human qualities of candidates who apply for positions at the Centre. It is essential that counsellors are empathic and sincere.

c) The recruitment of volunteers

In the past the Centre used only qualified counsellors as volunteers and I would recommend that this continue to be the case if the Centre is planning to use volunteers in the future. This is necessary because based on the results it is evident that in most cases unresolved issues emerge during the course of treatment. The counsellor has to be equipped to deal with these issues and lay counsellors may not have the necessary skills or knowledge to do so.

d) Fees

The issue of fees needs to be sensitively dealt with and The Trauma Centre will also have to ensure that fees are affordable because many of the clients come from lower income groups. Fees could be calculated on a sliding scale which is based on income.

e) Marketing of the Centre

I agree with the recommendation made by the one respondent that the Centre needs to advertise its services continually. This is to ensure that clients who need the service are aware of it. This would in turn increase the number of clients seen at the Centre, which has implications for both the lifespan and funding of the Centre.

The Centre could market itself through media interviews e.g. radio shows and magazine articles. It could also endorse and participate in events which attract public attention such as the annual men's march opposing violence against women. Posters advertising the Centre could be displayed in public areas e.g. train stations, bus stops and public toilets. Pamphlets could be distributed via medical practices, state hospitals and clinics.

Another aspect of marketing involves networking with other organizations and The Trauma Centre needs to pursue partnerships with relevant organizations for the same reasons mentioned above.

Another reason for these partnerships would be that the Centre would have more resources to which it can refer clients. This would thus improve the services to clients who do not meet the service criteria of the Centre.

g) Termination of counselling

Based on the results of the study counsellors need to be aware that clients will indicate what their needs are and that they can be seen as active 'partners' in their treatment.

Counsellors must not dictate what the duration of treatment will be and should reinforce the client's right to end treatment at any stage. This empowers the client and also if clients are told that they need to come for a certain number of sessions, they could perceive treatment as being involuntary. All the clients who attend the Centre for counselling have had an event imposed on them. It is vital that the Centre does not perpetuate the lack of choice by imposing treatment on clients.

h) Involving the family in treatment

The Centre does not routinely involve the family in treatment and I think this is an issue which needs to be considered by the organization. The results of the study and the literature confirm that the family can play a significant role in treatment. Counsellors could consider involving the family by educating them about what their relative is experiencing and how they can support and assist their relative. The needs of the family resulting from the trauma also need to be considered.

f) Ongoing evaluation

The need for ongoing evaluation has been embraced at The Trauma Centre and as from next year all clients will complete a pre – and post – counselling evaluation form. This is a very important step because not only will it facilitate future research but it will also allow ongoing evaluation of the Centre's work. This in turn will mean that services can be adjusted accordingly so that clients' needs can be met effectively. I would recommend that The Trauma Centre also implements other procedures which allow ongoing evaluation of the counselling process. This could possibly include peer evaluations of the counselling at the Centre.

4.3.2 Training

a) Staff development

All new staff must be obligated to attend the training offered by the Centre on trauma counselling because there are skills which are specific to trauma counselling for example how to do crisis counselling. This training should also consist of a component on how to evaluate the counselling of clients.

The Centre encourages staff to attend courses and conferences and this ensures that the counsellors are aware of developments in trauma counselling. The attendance of ongoing staff development is crucial because it will help to ensure that counsellors keep up with the latest developments in trauma management. The Centre also has an intensive weekly staff development programme which consists of topics which are relevant to the Centre's work. I would strongly recommend that this be continued for the same reason.

b) Training of volunteers

Volunteers should also receive ongoing training in trauma management in order to ensure that they are equipped to deal with the clients. They do not work with clients on a daily basis and the ongoing training will ensure that they practice their skills in trauma counselling even when they are not seeing clients. The training of volunteers can also be a way of ensuring that all volunteers have a similar baseline of knowledge in trauma management.

c) The importance of frontline staff

It is evident from the results that the frontline staff of the organization plays an important role in its relationship with its client population. The frontline staff therefore needs to be aware of the nature of their interaction with clients and they need to be trained in how to deal with clients especially distressed clients and how to deal with clients telephonically.

d) The supervision of staff

Supervision also consists of a training component and the supervision of staff is therefore important to maintain the high standard of work demonstrated in this evaluation of counselling from past clients' perceptions.

The staff at the Centre also attend group supervision with outside professionals and I would recommend that this be continued because it ensures that the staff also gain from the knowledge of trauma experts who do not work for the Centre.

4.3.3 Research

a) Creating a culture of research

I think that it is very positive that the Centre is attempting to create a culture of research within the organization. Staff are expected to conduct research and the Centre should consider providing staff with incentives, for example sponsoring staff who conduct research to attend international conferences. Ongoing research is essential because it ensures that the work of the Centre is meeting the needs of the clients, through research the counsellors will remain au fait with the latest trends in trauma management and the results of research projects can be used to support funding requests.

b) The administrative system

In order to encourage an ethos of research within the organization I would recommend that urgent attention be given to the filing and administrative systems of the Centre. It can be discouraging when files do not contain the required information and it also retards the research process. The Centre needs to develop a register which contains the status of all clients so that researchers have immediate access to lists of potential research candidates. This is important for continued evaluation and accountability.

c) Contacting clients post counselling

I would recommend that the Centre needs to be mindful of not approaching clients for research purposes when they are still attending counselling. I also think where possible clients should be contacted by their counsellor to prepare them that they will be contacted about participating in research. Ethical requirements must also be met for example clients must sign informed consent forms.

d) Other research**1) Client recommendations**

Client recommendations about the counselling service in order to inform the Centre of potentially necessary changes must be explored in terms of future research.

2) Non-return for counselling

A large number of clients did not meet the criteria for this research and this was partly because it would appear as if many clients do not return for counselling after the first session. This is an area that should be researched because it is important for the Centre to know the reasons for this non-return for counselling.

3) Including male counsellors

None of the respondents in this study were seen by a male counsellor and this information is still missing.

4) Involving the family in treatment

The Centre could also conduct research on how to involve the family in treatment.

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Confidential

REVISED IMPACT OF EVENT SCALE (MARDI HOROWITZ, 1979)

On _____ (date) you experienced (life event)

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you when you first came to The Trauma Centre. If they did not occur during that time, please mark the “not at all” column.

Frequency	Not at all	Rarely	Sometime	Often
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from my memory				
4. I had trouble falling asleep or staying asleep, because pictures or thoughts of it came into my mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it wasn't real.				
9 I tried not to talk about it.				
10. Pictures of it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had lots of feelings about it, but I didn't deal with it.				
13. Any reminder brought back feelings of it.				
14. I tried not think of it				
15. My feelings about it were kind of numb				
16. It affected me physically e.g. headaches, cramps				

Confidential

REVISED IMPACT OF EVENT SCALE (MARDI HOROWITZ, 1979)

On _____ (date) you experienced (life event)

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you when you ended your sessions at The Trauma Centre. If they did not occur during that time, please mark the “not at all” column.

Frequency	Not at all	Rarely	Sometime	Often
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from my memory				
4. I had trouble falling asleep or staying asleep, because pictures or thoughts of it came into my mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it wasn't real.				
9 I tried not to talk about it.				
10. Pictures of it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had lots of feelings about it, but I didn't deal with it.				
13. Any reminder brought back feelings of it.				
14. I tried not think of it				
15. My feelings about it were kind of numb				
16. It affected me physically e.g. headaches, cramps				

VERTROULIK

AFRIKAANSE HERSIENE IMPAKT VAN GEBEURE SKAAL (Mardi Horowitz, 1979)

Op _____ (datum) het u 'n ongewone lewenservaring of gebeurtenis beleef wat u lewe ernstig beïnvloed het, nl _____

Hieronder is 'n lys van kommentare deur mense na sodanige skokkende lewensevarings. Merk by elke item hoe dikwels hierdie kommentare toe u eers by die Trauma Centre gekom het, waar was. Indien dit nie gedurende daardie tyd voorgekom het nie, merk die Geensins kolom.

Frekwensie	Geensins	Selde	Soms	Dikwels
1) Ek het daaraan gedink al wou ek nie.				
2) Ek het dit vermy dat dit my ontstel as ek daaraan gedink het of daaraan herinner is.				
3) Ek het probeer om dit uit my geheue te verwyder.				
4) Ek het probleme gehad om aan die slaap te raak of aan die slaap te bly agv. beelde of gedagtes daaroor wat in my opgekom het.				
5) Ek het tye wat ek deur emosie oor die episode oorval word.				
6) Ek het gedroom daaroor.				
7) Ek vermy enigiets wat my daaraan herinner.				
8) Ek het gevoel asof dit nie gebeur het nie of asof dit onwerklik is.				
9) Ek het probeer om nie daaroor te praat nie.				
10) Beelde daaroor het kort-kort in my gedagtes opgekom.				
11) Ander dinge het my kort-kort daaraan laat dink.				
12) Ek was bewus daarvan dat ek steeds 'n klomp gevoelens daaroor het, maar dat ek hulle nog nie hanteer het nie.				
13) Ek het probeer om nie daaraan te dink nie.				
14) Enige herinnering het weer gevoelens daaroor losgemaak				
15) My gevoelens daaroor is afgestomp/dof of dood				
16) Dit het me fisies afekteer bv. Krampe, kopseer				

VERTROULIK

AFRIKAANSE HERSIENE IMPAKT VAN GEBEURE SKAAL (Mardi Horowitz, 1979)

Op _____ (datum) het u 'n ongewone lewenservaring of gebeurtenis beleef wat u lewe ernstig beïnvloed het, nl _____

Hieronder is 'n lys van kommentare deur mense na sodanige skokkende lewensevarings. Merk by elke item hoe dikwels hierdie kommentare toe u by die Trauma Centre klaar gemaak het, waar was. Indien dit nie gedurende daardie tyd voorgekom het nie, merk die Geensins kolom.

Frekwensie	Geensins	Selde	Soms	Dikwels
1) Ek het daaraan gedink al wou ek nie.				
2) Ek het dit vermy dat dit my ontstel as ek daaraan gedink het of daaraan herinner is.				
3) Ek het probeer om dit uit my geheue te verwyder.				
4) Ek het probleme gehad om aan die slaap te raak of aan die slaap te bly agv. beelde of gedagtes daaroor wat in my opgekom het.				
5) Ek het tye wat ek deur emosie oor die episode oorval word.				
6) Ek het gedroom daaroor.				
7) Ek vermy enigiets wat my daaraan herinner.				
8) Ek het gevoel asof dit nie gebeur het nie of asof dit onwerklik is.				
9) Ek het probeer om nie daaroor te praat nie.				
10) Beelde daaroor het kort-kort in my gedagtes opgekom.				
11) Ander dinge het my kort-kort daaraan laat dink.				
12) Ek was bewus daarvan date k steeds 'n klomp gevoelens daaroor het, maar dat ek hulle nog nie hanteer het nie.				
13) Ek het probeer om nie daaraan te dink nie.				
14) Enige herinnering het weer gevoelens daaroor losgemaak				
15) My gevoelens daaroor is afgestomp/dof of dood				
16) Dit het me fisies afekteer bv. Krampe, kopseer				

Appendix II

Interview Schedule

Re introduction of self and study- include clarification of the goals/aims of the study and what will be done with information received i.e. do thorough contract. Ensure that client understands contract.

Explore BRIEFLY what their traumatic event was and how many counselling sessions they had.

Get them to fill in questionnaire regarding symptoms on presentation.

Explore their experience of the counselling process - look at what was most helpful/ least helpful about the process.

Explore their perceptions of their counsellor especially characteristics which was most/least helpful.

What recommendations do they have about the services at the Trauma Centre?

Get subject to fill in second questionnaire i.e. their current symptoms.

Would they recommend/ not recommend counselling at Trauma Centre and why?

Discuss one significant way in which trauma counselling changed them.

How did counsellor facilitate this?

General comments about the research interview also ensure that they are contained. Reflect that interview may have raised issues and that a counsellor will be available if they need to talk to someone.

Appendix III
Copy of feedback letter

8 March 2004

Dear _____

Thank you, once again for participating in the research study which I conducted in October and November last year. I have at last finalised the results and I am very pleased that I am now able to share the findings of the study with you as I had agreed to do. The following were the key findings of my research:

- 1) All of the people interviewed were happy with the counselling that they received at the centre.**
- 2) This was largely due to the fact that they felt that the counsellors were supportive, understanding and experts in the field of trauma management.**
- 3) Clients attended an average of 4.7 sessions and the majority also discussed issues besides the event as well.**
- 4) Everybody also experienced the same types of emotions (for example fear) and symptoms when they first began counselling.**
- 5) The results indicate that all of the respondents experienced an improvement of their symptoms.**
- 6) Some recommendations for the centre were made for example that The Trauma Centre needs to market itself more so that more people know of the service.**

If you would like more information about the results please feel free to contact me at 465 7373 on Mondays- Wednesdays. If the interview did evoke any feelings for you please remember that you are welcome to contact your counsellor for a follow-up session. Thank you once again for the time that you gave to be part of this study. Your input has been very valuable and I wish you well for the future

Yours sincerely

Fatima Williams

Counsellor
Trauma Response Team